CHAPTER V

BILLING INSTRUCTIONS

CHAPTER V
TABLE OF CONTENTS

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VIRGINIA MEDICAL ASSISTANCE PROGRAM – NURSING FACILITY BILLING INVOICES

The use of the appropriate billing invoice depends upon the type of service being rendered by the provider or the billing transaction being completed. Listed below are the three billing forms that will be used:

- UB-92 (HCFA-1450) Claim Form (for both billing and adjustments)
- Title XVIII (Medicare) Deductible and Co-insurance Invoice, DMAS-30 (Skilled Nursing Facility only)
- Title XVIII (Medicare) Deductible and Co-insurance Adjustment Invoice, DMAS-31 (Skilled Nursing Facility only)

SUBMISSION OF BILLING INVOICES

Nursing homes should submit the billing invoice within 15 days from the date of the last service or discharge. The original copy of the invoice is submitted to the Virginia Medicaid Program to obtain payment for the services rendered. Proper postage amounts are the responsibility of the provider and will help prevent mishandling. All invoices must be mailed; messenger or hand deliveries will not be accepted.

Providers are to use appropriate envelopes, but they should be sent to the post office box shown below. **Do not send invoices or adjustments to the central Department of Medical Assistance Services (DMAS) office unless specifically requested to do so by a Medicaid staff member,** as this causes a delay in the payment process. The Medicaid claim mailing address is:

DMAS - Nursing Facility
P.O. Box 27442
Richmond, Virginia 23261-7442

All other mail should be sent to:

Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Include the individual's name and division or section name in the address when possible. This will help facilitate more accurate and efficient mail distribution.

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered directly into the claims processing system. For more information, contact our Fiscal Agent, First Health Services Corporation (FHSC):

Phone: 1-888-829-5373 and choose option 2 (EDI – Electronic Data Interchange)
Fax: 1-804-273-6797

First Health's website: http://virginia.fhsc.com
Email: edivmap@fhsc.com

Mailing Address

EDI Coordinator - Virginia Operations
First Health Services Corporation (FHSC)
4300 Cox Road
Richmond, Virginia 23060

Electronic Billing Attachment Form - A new attachment form (DMAS-3) will be available for electronic billers to use **only** to submit a non-electronic attachment to an electronically-submitted claim. An Attachment Control Number (ACN) must be entered on the electronic claim submitted. The ACN consists of the combined fields of the patient account number, date of service, and sequence number. (See the FHSC website at http://virginia.fhsc.com for electronic claim transmission specifications.)

IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM, OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, THE CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS, OR THE CLAIM MAY RESULT IN A DENIAL. A sample of the new form is included in the "Exhibits" section at the end of this chapter. Copies of the DMAS-3 form may be downloaded from the DMAS website at www.dmas.virginia.gov.

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross reference number, and entered into the system, it is placed in one of the categories mentioned below.

- Remittance Voucher
    - **Approved** - Payment is approved or placed in a pending status for manual adjudication (the provider must not resubmit).
    - **Denied** - Payment cannot be approved because of the reason stated on the Remittance Voucher.

- No Response - If one of the above responses has not been received within 30 days of submission, the provider should assume non-delivery and re-bill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

TIMELY FILING

The Virginia Medical Assistance Program regulations require prompt submission of all claims. The Virginia Medicaid Program is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims which **are not** submitted within 12 months from the date of the service. The DMAS-3 form is to be used by electronic billers for attachments (see the "Exhibits" section at the end of this chapter). Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility -** Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely manner, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility -** Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months old when the claims are for a recipient whose eligibility has been delayed. When the provider did not have knowledge of the Medicaid eligibility of the person prior to rendering the care or service, he/she has 12 months from the date he/she is notified of the Medicaid eligibility in which to file the claim. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a data letter from the local Department of Social Services (DSS) office, which specifies that the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

  The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the receipt of the notification of the delayed eligibility. A copy of the **dated** letter from the local DSS office indicating the delayed claim information must be attached to the claim; to request individual consideration, enter an explanation in the "Remarks" section of the invoice.

- **Denied Claims** - Denied claims that have been submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedure for resubmission is as follows:

  - Complete the invoice as usual and request individual consideration for the late submission of the invoice by explaining the reason for the late submission in the

"Remarks" section of the invoice;

- Attach written documentation to verify the explanation. The attached documentation may be photocopies of invoices or denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period; and

- Submit the claim in the usual manner by mailing the claim to:

  DMAS - Nursing Facility
  P. O. Box 27442
  Richmond, Virginia 23261-7442

  The original invoice form should be submitted. A copy should be retained by the provider for record keeping. All invoices must be mailed. Proper postage is the responsibility of the provider and will help prevent mishandling. Messenger or hand deliveries will not be accepted.

- **Exceptions** - The state Medicaid agency is required to adjudicate all claims within 12 months of receipt, except in the following circumstances:

  - The claim is a retroactive adjustment paid to a provider who is reimbursed under a retrospective payment system.

  - Medicaid has suspended payment to the provider during an investigation, and the investigation exonerates the provider.

  - The payment is in accordance with a court order to carry out hearing decisions or agency corrective actions taken to resolve a dispute or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

    The procedures for the submission of these claims are the same as previously outlined. The required documentation should be written confirmation that the reason for the delay meets one of these specified criteria.

  - **Accident Cases** - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid, as the time limit for filing the claim has expired.

  - **Pre-authorized Services for Retroactive Eligibility** - For services requiring pre-authorization, all pre-authorization criteria must be met for the claim to be paid. For those services occurring in a retroactive eligibility period, after-the-fact authorizations will be performed by DMAS.

- **Other Primary Insurance** - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

All pre-authorization requests must be submitted in a timely manner. Requests that are received for services older than 12 months will be denied, and reimbursement will not be made. Exceptions to pre-authorization requests for services older than 12 months will only be made in accordance with those exceptions applicable to claims payment as defined in this chapter.

REPLENISHMENT OF BILLING MATERIALS

The hospital provider must purchase the UB-92 Claim Forms. (The Virginia Hospital and HealthCare Association has a group purchasing plan, or the hospital provider can check with the vendor of its choice.)

As a general rule, DMAS will no longer provide a supply of agency forms, because they can be downloaded from the DMAS website (www.dmas.virginia.gov). To view or access the forms used by DMAS, click on "Search Forms" along the left-hand side of the DMAS home page and select "Provider" in the "User" field to access provider forms. Then you may either search by form name or number. If you do not have Internet access, you may request a form for copying by calling the DMAS Form Order Desk at 1-804-780-0076.

REMITTANCE/PAYMENT VOUCHER

DMAS sends a check and Remittance Voucher with each weekly payment made by the Virginia Medical Assistance Program. The Remittance Voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The Remittance Voucher includes an address location which contains the provider's name and current mailing address as shown in the DMAS provider enrollment file. In the event of a change of address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that the DMAS Provider Enrollment and Certification Unit be notified in sufficient time prior to a change of address in order for the provider files to be updated.

Providers are encouraged to monitor the Remittance Vouchers for special messages since they serve as notifications of matters of concern, interest, and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice Transaction Set is used to communicate the results of claim adjudication. DMAS will make a payment with an electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835 Claims Payment Advice Transaction Set. In addition to the 835 Claims Payment Advice Transaction Set, the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claims Payment Advice Transaction Set, please contact our Fiscal Agent, First Health Services Corporation, at 1-888-829-5373 and choose option 2 (EDI).

ELECTRONIC FILING REQUIREMENTS

The Virginia Medicaid Management Information System (VAMMIS) is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions will not be accepted after October 15, 2003, and all Local Service Codes will no longer be accepted for claims with dates of service after October 15, 2003. All claims submitted with dates of service after October 15, 2003, will be denied if Local Codes are used.

DMAS will accept the National Standard Format (NSF) for electronic claims submitted on or before October 15, 2003. On June 20, 2003, EDI transactions according to the specifications published in the ASC X12 Implementation Guides, version 4010A1 (HIPAA-mandated) will also be accepted. Beginning with electronic claims submitted on or after October 16, 2003, DMAS will only accept HIPAA-mandated EDI transactions (claims in National Standard Format will no longer be accepted). National Codes that replace Local Codes will be accepted for claims with dates of service on or after June 20, 2003. National Codes become mandatory for claims with dates of service on or after this date.

The transactions for hospital claims include:

- 837P for submission of professional claims;
- 837I for submission of institutional claims;
- 837D for submission of dental claims;
- 276 & 277 for claims status inquiry and response;
- 835 for Remittance Advice information for adjudicated (paid and denied) claims;
- 270 & 271 for eligibility inquiry and response;
- 278 for prior authorization request and response; and
- Unsolicited 277 for reporting information on pended claims.

Information on these transactions can be obtained from our Fiscal Agent's website: http://virginia.fhsc.com.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

CLAIMCHECK

ClaimCheck is a fully automated auditing system that verifies the clinical accuracy of claims submitted and reimbursed. DMAS uses ClaimCheck as a post-payment review of professional and laboratory claims. As a result of this auditing process, DMAS makes the necessary voids to or adjustment of the claim(s).

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state laws.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. DMAS maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

PROVIDER FRAUD

The provider is responsible for complying with applicable state and federal laws and regulations and the requirements set forth in this manual. If electronically submitting claims or using electronic submission, use EDI Format, version 5, prior to May 31, 2003. For electronic submissions on or after June 3, 2003, use EDI transaction specifications published in the ASC X12 Implementation Guides, version 4040A1. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his/her signature, or the signature of his/her authorized agent, on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be

prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with the appropriate supportive evidence:

Supervisor, Provider Review Unit
Division of Program Integrity
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General for Virginia
900 East Main Street, 5th Floor
Richmond, Virginia 23219

RECIPIENT FRAUD

Allegations about fraud or abuse by recipients are investigated by the Recipient Audit Unit of DMAS. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid or failed to report changes, or both, that if known would have resulted in ineligibility. The unit also investigates incidents of card sharing and prescription forgeries.

If it is determined that benefits, to which the individual was not entitled, were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of 12 months beginning with the month of the fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Section
Division of Program Integrity
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

INQUIRIES CONCERNING BILLING PROCEDURES

Inquiries concerning covered benefits, specific billing procedures, or remittances should be directed to the HELPLINE staff at this address:

Provider Inquiry Unit
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Phone:	1-804-786-6273	Richmond area and out-of-state long distance
	1-800-552-8627	In-state, toll-free long distance

Recipient verification may be obtained by calling:

1-800-884-9730	Toll-free throughout the U.S.
1-804-965-9732	Richmond and surrounding counties
1-804-965-9733	Richmond and surrounding counties

The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays.

INQUIRIES CONCERNING UB-92 MEDICARE CROSSOVER PART A AND PART B CLAIMS

This information relates to the paper submission of UB-92 Medicare Crossover Part A and B claims. Detailed billing instructions for UB-92 Medicare Crossover part A and B claims were provided in the March 18, 2004 Medicaid Memo entitled "Billing Information Correction for Submitting Paper UB-92 Medicare Part A and B Claims." DMAS is providing this additional billing information in response to questions from providers and observed billing problems.

- Many handwritten claims submitted to our Fiscal Agent, First Health Services Corporation (FHSC), have been recorded incorrectly in the claims adjudication system due to errors in scanning and data entry. It is best if the nursing facility provider can produce typewritten UB-92 claims in no less than non-compressed 12 pitch. Detailed instructions for minimizing Optical Character Recognition (OCR) problems are available on the DMAS website at www.dmas.virginia.gov under "Provider Services" in Attachment 2 of the May 1, 2003 Medicaid Memo entitled "All Providers: Implementation of the New Virginia Medicaid Management Information System (MMIS)." DMAS staff is working closely with FHSC management to address scanning problems that may be associated with its software and procedures.

- Due to a logic problem in an edit (that has been corrected), some Medicare-to-Medicaid crossover claims for nursing facilities were receiving an incorrect error code. In these circumstances, claims were denied for reason 0244, "Medicare Remittance (EOMB) Not Attached," when in fact an EOMB was attached. If processed correctly, some of these claims would have denied for reason 0364, "Primary Carrier Payment Equals or Exceeds

DMAS' Allowed Amount." Letters have been sent to United Government Services explaining this problem. If needed for Medicare reporting purposes, you can obtain additional copies of the letters at www.dmas.virginia.gov by clicking on "Provider Services," then "Manuals, Memos, and Communications," and then "Letters to Providers."

- A Medicare Explanation of Benefits (EOMB) is only required when a Coordination of Benefits (COB) code of 85 is used in Locators 39-41. COB codes 82 and 83 do not require an EOMB to be attached to the Medicare Crossover claim.

- Locator 7 (Covered Days) should always reflect the number of Medicaid-covered days as applicable for Medicare Part A and B claims. For inpatient claims, the number of days in Locator 7 must equal the number of Accommodation Revenue Codes billed in Locator 46. For outpatient claims, the number of units provided in Locator 46 should reflect the actual number of visits (units) provided for the specific service(s) (e.g., Physical Therapy, Occupational Therapy, Speech Therapy, etc.) within the time frame indicated in Locator 6.

- UB-92 claims must not exceed three pages. DMAS recommends that nursing facilities that exceed the allowed number of revenue lines roll up the same revenue code on the claim versus using separate lines for the same revenue code. Virginia Medicaid does not require the specific date of service for each revenue code.

The issues addressed below are a restatement of billing requirements that were communicated in the Medicaid Memo dated October 28, 2003, entitled "Changes in Billing for Medicare 'Crossover' Claims." Other issues addressed in this memorandum are based on questions from providers and billing problems that have been observed. DMAS is providing some additional information to help clarify these issues including detailed billing instructions for UB-92 Medicare Part A and B claims.

- For Nursing Facility Services, the appropriate paper invoice to use when billing DMAS is determined by which form is used to bill the service to Medicare. This is a correction to the Medicaid Memo dated October 28, 2003. If Medicare is billed using the UB-92 Claim Form, then the paper crossover claim should be billed to DMAS on the UB-92 Claim Form. Skilled nursing facilities should use **Bill Type 211** for Part A Medicare Deductible and Co-insurance claims and **Bill Type 221** for Part B Medicare Deductible and Co-insurance claims. Non-skilled nursing facilities use **Bill Type 611** for Part A Medicare Deductible and Co-insurance claims and **Bill Type 621** for Part B Medicare Deductible and Co-insurance claims. If the CMS-1500 (12-90) Claim Form is used to bill Medicare for Part B, then the Medicaid Title XVIII Deductible and Co-insurance Invoice must be used to bill for Part B claims. However, DMAS does not expect nursing homes to use the Title XVIII (Medicare) Invoice to bill Medicare Part B claims with the exception of Durable Medical Equipment Regional Carrier (DMERC) supplies that were billed to the Medicare Intermediary.

- Enter the word **"CROSSOVER"** in Block 11 of all UB-92 paper claim submissions for originals, adjustments, and voids. This is the only way our automated claims processing system can identify the claim as a Medicare crossover claim. Without the word

"CROSSOVER" entered in Block 11, the claim will process as a regular Medicaid claim and not calculate the co-insurance and deductible amounts.

- A five-digit procedure code **should not** be entered in Block 80 (Principal Procedure Code) of the UB-92 Medicare Part B paper claim submission. Block 80 **must be left blank** for UB-92 Medicare Part B paper claims. If applicable, an ICD-9-CM procedure code should be entered in Block 80 for Medicare Part A claims.

- COB codes (83 and 85) must accurately be printed in Blocks 39-41 of the UB-92 Claim Form. The first occurrence of COB code 83 indicates that Medicare paid, and there should always be a dollar value associated with this COB code. Code A1 indicates the Medicare deductible, and code A2 indicates the Medicare co-insurance. COB code 85 is to be used when another insurance is billed, and there is not a payment from that carrier. For the deductibles and co-insurance due from any other carrier(s) (not Medicare), the code for reporting the amount paid is B1 for the deductibles and B2 for the co-insurance. The national standard for billing value codes is to complete Blocks 39a - 41a before proceeding to Block 39b. This is also a correction to the October 28, 2003 Medicaid Memo.

- Medicare Part A and B claims for individuals with third party coverage have resulted in incorrect denials for edit 0313 "Bill Any Other Available Insurance." The denials were a result of the incorrect system manipulation of COB code 85 (Billed and Not Paid). Claims incorrectly denied for this reason will be reprocessed. However, it is important to note that original crossover claims from the Medicare Intermediary are correctly denied for edit 0313 when the Medicaid recipient has insurance coverage in addition to Medicare and Medicaid. The intent is for the provider to exhaust all insurance coverage before billing Medicaid, which is the payer of last resort.

- Block 77 on the UB-92 Claim Form is **not** required. The instructions in the October 28, 2003 Medicaid Memo erroneously indicated that this field is required.

UB-92 (HCFA-1450) BILLING INSTRUCTIONS

Instructions for Completing the UB-92 (HCFA-1450) Claim Form

The UB-92 (HCFA-1450) Claim Form is a universally accepted claim form that is required when billing DMAS for covered services. This form is readily available from printers. The UB-92 (HCFA-1450) Claim Form **will not** be provided by DMAS. (See the "Exhibits" section at the end of this chapter for a sample of this form.)

General Information

The following information is applicable to Medicaid claims submitted by the provider on the UB-92 (HCFA-1450) Claim Form:

- All dates used on the UB-92 (HCFA-1450) Claim Form must be two digits each for the day, month, and year (e.g., 010403 for January 4, 2003) with the exception of Locator 14, "Patient Birth Date," which requires four digits for the year.

  NOTE: NO SLASHES, DASHES, OR SPACES ARE ALLOWED.

- Where there are A, B, and C lines, complete all the A lines, then all the B lines, and finally the C lines. Do not complete A, B, C, and then another set of A, B, C.

- Do not record cost reduction co-payments on this form.

- When coding ICD-9-CM diagnostic and procedure codes, do not include the decimal point. The use of the decimal point may be misinterpreted in claims processing.

- Continue to use the Medicare Title XVIII Deductible and Co-insurance Invoice (DMAS-30, Revised 6/03) when appropriate.

- To adjust a previously paid claim, complete the UB-92 (HCFA-1450) Claim Form to reflect the proper conditions, services, and charges. In addition, in Locator 4 ("Type of Bill") enter code 217, 227, 228, 617, 627, or 628 for Nursing Facility Services and, in Locator 37, enter the nine or sixteen- digit claim reference number of the paid claim to be adjusted. The claim reference number appears on the Remittance Voucher. Enter the reason code and an explanation for the adjustment in the "Remarks" section, Locator 84.

- To void a previously paid claim, complete the following data elements on the UB-92 (HCFA-1450) Claim Form:

  - "Type of Bill" (Locator 4) - Enter code 217, 218, 227, 228, 617, 618, 627, or 628 for Nursing Facility Services.

  - "ICN/DCN" (Locator 37) - Enter the nine or sixteen-digit claim reference number of the paid claim to be voided. Enter the reason code and an explanation in the "Remarks" section, Locator 84.

- "Payer Indicator" (Locator 50) - Enter "Medicaid" here.
- "Medicaid Provider Number" (Locator 51) - Enter the Medicaid Provider Number.
- "Recipient ID Number" (Locator 60) - Enter the enrollee's Virginia Medicaid Number.

UB-92 (HCFA-1450) BILLING REQUIREMENTS – NURSING FACILITIES (INPATIENT)

The following instructions outline the process for completing the UB-92 (HCFA-1450) Claim Form.

Form Locator (FL)		Instructions
1	**Required**	Enter the provider's name, address, and telephone number.
2	Unlabeled Field	
3	**Required (if applicable)**	**PATIENT CONTROL NO. -** Enter the nursing facility patient account number. These account numbers may be all numeric digits or a combination of alpha and numeric, but cannot exceed 17 alphanumeric characters.
4	**Required**	**TYPE OF BILL** - Enter the code as appropriate. For billing on the UB-92 Claim Form, the only valid codes for Virginia Medicaid are: 211 Original Nursing Facility Invoice 217 Adjustment Nursing Facility Invoice 218 Void Nursing Facility Invoice 221 Skilled Nursing Inpatient Invoice 227 Skilled Nursing Inpatient Invoice, Adjustment 228 Skilled Nursing Inpatient Invoice, Void 611 Original Specialized Care Invoice 617 Adjustment Specialized Care Invoice 618 Void Specialized Care Invoice 621 Intermediate Care Inpatient Invoice 627 Intermediate Care Inpatient Invoice, Adjustment 628 Intermediate Care Inpatient Invoice, Void
5	Not Required	FED. TAX NO.
6	**Required**	**STATEMENT COVERS PERIOD** - Enter the inclusive days being reported on the invoice. The "through" entry must be the last day billed. The date of death or discharge, if applicable, must be indicated. The "Statement Covers Period" on the invoice must fall within one calendar month. When there is a claim for which the billing period overlaps calendar months, a separate invoice must be submitted for each calendar month. For example, an enrollee admitted to a nursing facility on March 15 and discharged on

Form Locator (FL)		Instructions
		April 30 means one invoice would be submitted for the period of March 15 through March 31, and one invoice would be submitted for the period of service in April.
7	**Required**	**COV D. (Covered Days)** - Enter the total number of Medicaid covered days as applicable. This must be the total number of covered accommodation days/units reported in Locator 46.
8	**Required (if applicable)**	**N-CD. (Non-Covered Days)** - Enter the days of care not covered. Non-covered days are not included in covered days and not claimable as Medicaid patient days on the cost report.
9	Not Required	C-ID. (Co-insurance Days)
10	Not Required	L-RD. (Lifetime Reserve Days)
11	**Required (if applicable)**	Enter the word "crossover" if **Medicare** is primary.
12	**Required**	**PATIENT NAME** - Enter the patient's name (last, first, middle initial).
13	Not Required	Patient Address - Enter the patient's address.
14	**Required**	**Birth Date -** Enter the month, date, and full year (MMDDYYYY).
15	**Required**	**Sex** - Enter the sex of the patient as recorded at the date of admission, outpatient service, or start of care.
16	Optional	MS (Patient's Marital Status) - Enter the marital status of the patient at the date of admission or the start of care. The codes are: S = Single M = Married X = Legally Separated D = Divorced W = Widowed U = Unknown
17	**Required**	**ADMISSION** - Enter the date of admission to the nursing facility. **NOTE**: Edit 0919 – "Inpatient hospital" versus "nursing facility" is being captured due to an incorrect admission date for the nursing facility claim being submitted. If a nursing facility has received payment for a hospitalized recipient, where the nursing facility did not adjust the admission date to reflect a new admission date upon return from the hospital, the nursing facility claim(s) must be voided by the nursing facility and resubmitted

Form Locator (FL)		Instructions
		with the correct re-admission date for all claims submitted incorrectly. Updating the admission date on the claim does not have any effect on the PIRS admission process, nor does it require the submission of a new PIRS (Patient Intensity Rating System) form to change an admission date.
18	Not Required	HR (Admission Hour)
19	Not Required	Type (Type of Admission)
20	**Required**	**SRC (Source of Admission)** - Enter the proper code as follows: 1 Physician Referral (used for both Inpatient and Outpatient Referrals) 2 Clinic Referral (used for both Inpatient and Outpatient Referrals) 3 HMO Referral (used for both Inpatient and Outpatient Referrals) 4 Transfer from a hospital 5 Transfer from a skilled nursing facility 6 Transfer from another health care facility 7 Emergency room 8 Court/law enforcement 9 Information not available A Transfer from a critical access hospital BZ Reserved for national assignment
21	Not Required	D HR (Discharge Hour)
22	**Required**	**STAT (Patient Status)** - Enter the status code as of the "through" date in Statement Covers Period (Locator 6). (If the patient was a one-day stay, enter code "30.") DMAS does not pay for a nursing facility bed to be held while a patient is hospitalized.

Form Locator (FL) Instructions

30 - Still a Patient - The last day in the service period is the "through" date in Locator 6. This date must be included in the accommodation charges in Locator 46.

1 - Transferred Hospital - The date the patient was transferred is the "through" date in Locator 6. This date is not included in the accommodation charges in Locator 46.

For a patient in the nursing facility a whole month, the "from" date will be the first day of the month. The "through" date is the last day of the month (e.g., from 03/01/03 through 03/31/03). The patient status code will be "30" (still a patient), which ensures payment for the last day.

When a patient is admitted to a hospital or discharged (e.g., on 04/14/03), bill for 04/01/03 to 04/14/03, using the appropriate codes 1-8 (discharge codes). The day of death or discharge is not a covered day, so the accommodation days will be 13. Locators 6 and 46 must be coordinated and in agreement.

When status codes 1-8 are used in Locator 22, the "through" date is not a paid accommodation day.

If the patient returns to the nursing facility, a second bill will begin the date of the return to the facility. If the patient returns on 04/25/03, the second bill for April will have a "from" date of 04/25/03 and a "through" date of 04/30/03, with a patient status of "30."

DMAS does not pay for a nursing facility bed to be held while a patient is hospitalized.

2 - Discharged/Transferred to Skilled Nursing Facility - The date the patient was transferred is the "through" date in Locator 6. This day cannot be included in the accommodation charges in Locator 46. [Used by Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Institutes for Mental Disease (IMD) only.]

3 - Discharged/Transferred to Nursing Facility - The day the patient was transferred is the "through" date in Locator 6. This day cannot be included in the accommodation charges in Locator 46. (Used by ICF/MR and IMD facilities only.)

Form Locator (FL) Instructions

4 - Discharged/Transferred Other - The date the patient was transferred is the "through" date in Locator 6. This day cannot be included in the accommodation charges in Locator 46. If discharged or transferred to or from Specialized Care, use this code.

NOTE: When a patient is transferred from a Specialized Care bed to a nursing facility bed within the same facility, the day of transfer is considered the day of discharge from Specialized Care. This date is **not covered** for Specialized Care**.**

5 - Discharged Home/Self Care - The date the patient was discharged must be reported in Locator 6 as the "through" date. This day cannot be included in the accommodation charges in Locator 46.

6 - Discharged/Home Health Agency - The date the patient was discharged must be reported in Locator 6 as the "through" date. This day cannot be included in the accommodation charges in Locator 46.

7 - Left Against Advice - The date the patient left must be reported in Locator 6 as the "through" date. This date cannot be included in the accommodation charges in Locator 46.

8 - Died - The date of death must be reported in Locator 6 as the "through" date. This date cannot be included in the accommodation charges in Locator 46.

For claims submitted with postmarks on or after June 1, 2003, these National Codes are to be used:

01 - Discharged to Home or Self Care (routine discharge).

02 - Discharged/Transferred to Another Short-Term General Hospital for Inpatient Care. The date the patient was transferred is the "through" date in Locator 6. This day cannot be included in the accommodation charges in Locator 46. (Used by ICF/MR and IMD facilities only.)

03 - Discharged/Transferred to Skilled Nursing Facility (SNF). The day the patient was transferred is the "through" date in Locator 6. This day cannot be included in the

Form Locator (FL) Instructions

accommodation charges in Locator 46. (Used by ICF/MR and IMD facilities only.)

04 - Discharged/Transferred to an Intermediate Care Facility (ICF). The date the patient was transferred is the "through" date in Locator 6. This day cannot be included in the accommodation charges in Locator 46. If discharged or transferred to or from Specialized Care, use this code.

NOTE: When a patient is transferred from a Specialized Care bed to a nursing facility bed within the same facility, the day of transfer is considered the day of discharge from Specialized Care. This date is **not covered** for Specialized Care**.**

05 - Discharged/Transferred to Another Type of Institution for Inpatient Care or Referred for Outpatient Services to Another Institution. The date the patient was discharged must be reported in Locator 6 as the "through" date. This day cannot be included in the accommodation charges in Locator 46.

06 - Discharged/Transferred to Home Under Care of Organized Home Health Service Organization. The date the patient was discharged must be reported in Locator 6 as the "through" date. This day cannot be included in the accommodation charges in Locator 46.

07 - Left Against Medical Advice or Discontinued Care. The date the patient left must be reported in Locator 6 as the "through" date. This date cannot be included in the accommodation charges in Locator 46.

20 - Expired - The date of death must be reported in Locator 6 as the "through" date. This date cannot be included in the accommodation charges in Locator 46.

23 Optional Medical Record No. - Enter the number assigned to the patient's medical/health record by the provider for history audits.

NOTE: This number should not be substituted for the Patient Control Number (Locator 3), which is assigned by the provider to facilitate retrieval of the individual financial record.

24-30 Not Required Condition Codes

Form Locator (FL)		Instructions
31	Unlabeled Field	
32-35	**a-b Required (if applicable)**	**OCCURRENCE CODES AND DATES** - Enter the code(s) in numerical sequence (starting with 01) with the associated date to define a significant event relating to this bill that may affect payer processing. **01 - Auto Accident** - Code indicating the date of an auto accident. **02 - No-Fault Insurance Involved - Including Auto Accident/Other -** Code indicating the date of an accident including auto or other where the state has applicable no-fault liability laws (i.e., legal basis for settlement without admission of proof of guilt). **03 - Accident/Tort Liability -** Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability. **04 - Accident/Employment Related -** Code indicating the date of an accident allegedly relating to the patient's employment. **05 - Other Accident -** Code indicating the date of an accident not described by the above codes. **06 - Crime Victim -** Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
36	Not Required	Occurrence Span Codes and Dates
37	**a-c Required (if applicable)**	**INTERNAL CONTROL NUMBER (ICN)** **DOCUMENT CONTROL NUMBER (DCN)** - Enter the nine or sixteen-digit claim reference number of the paid claim to be **adjusted** or **voided**. A brief explanation of the reason for the adjustment or void is required in Locator 84 (Remarks). See the instructions for adjustments and voids for the specific reasons. **NOTE:** A = Primary Payer B = Secondary Payer

Form Locator (FL)		Instructions
		C = Tertiary Payer
		Cross Reference to Payer Identification in Locator 50 - A, B, C (Payer Identification).
38	Optional	Responsible Party Name and Address
39-41	**Required**	**VALUE CODES AND AMOUNTS** - Enter the appropriate code(s) to relate amounts or values to identified data elements necessary to process this claim.

The Virginia Medical Assistance Program is always the payer of last resort when other health insurance coverage is available. Thus, all other insurance companies must be billed and payment received before billing the Virginia Medical Assistance Program.

Other health insurance coverage will be provided at the time of verification of the enrollee's eligibility. This code consists of a three-digit numerical code denoting a possible carrier. Information
for these carriers must be obtained by contacting the appropriate carrier.

Each claim submitted **must** include the appropriate code in Locator 39 to indicate the primary carrier billing status.

One of the following codes **must** be used:

82 - No Other Coverage - If the enrollee has no insurance coverage other than Medicare and Medicaid.

83 - Billed and Paid - The Virginia Medical Assistance Program must only be billed if the amount paid by the primary carrier is less than the charge for the covered services rendered. If the provider has received payment from the primary carrier(s) other than Medicare Part A, code 83 must be entered, all applicable charges must be entered, and the amount covered by the primary carrier must be entered under the "Amount" section of the locator.

85 - Billed and Not Paid - It is possible that the health insurance coverage of the primary carriers may exclude a particular type of service that is covered under the Virginia Medical Assistance Program, or, after billing the primary carrier, it may be determined that the enrollee's other coverage for certain benefits may be exhausted. In either case, Code 85 must be entered. The use of Code 85 must be accompanied by an attachment that contains the following

Form Locator (FL)		Instructions
		information: the name of the insurance, the date of denial, and the reason for denial or non-coverage. This denial must be part of the patient's record and available for audit.
42	**Required**	**REV. CD. (Revenue Codes) -** Enter the appropriate revenue code(s) which identify a specific accommodation, ancillary service, or billing calculation. Code = Four digits, right-justified, may use leading zeros. Revenue codes allowed by DMAS for use by nursing facilities are shown in the "Exhibits" section for your referral.
43	**Required**	**DESCRIPTION - Enter the National Uniform Billing Committee (NUBC) description and abbreviation (refer to the *State UB-92 Manual*).**
44	**Required**	**CPCS/RATES** - Enter the accommodation rate.
45	Not Required	SERV. DATE - Enter the date the service was provided.
46	**Required**	**SERV. UNITS -** Enter the total number of covered accommodation days or ancillary units of service where appropriate.
47	**Required**	**TOTAL CHARGES (by Revenue Codes)** - Enter the total charge(s) pertaining to the related revenue code for the current billing period (total charges must include only covered charges). **Instructions for 0001** **Use revenue code "0001" for TOTAL. THIS REVENUE CODE MUST BE THE LAST CODE ENTERED IN Form Locator 42.**
48	**Required**	**NON-COVERED CHARGES** - Reflects non-covered charges for the primary payer pertaining to the related revenue code. **Note**: Use revenue code "0001" for TOTAL Non-Covered Charges. (Enter the total for both total charges and non-covered charges on the same line of revenue code "0001.")
49	Unlabeled Field	

Form Locator (FL)		Instructions
50	**A-C Required**	**PAYER** - Identifies each payer organization from which the provider may expect some payment for the bill. A = Enter the primary payer. B = Enter the secondary payer if applicable. C = Enter the tertiary payer if applicable. When Medicaid is the only payer, enter "Medicaid" on Line A. If Medicaid is the secondary or tertiary payer, enter on Lines B or C as appropriate.
51	**A-C Required**	**PROVIDER NO.** - Enter the Provider I.D. NUMBER on the appropriate line corresponding with the payer name in locator 50. A = Primary B = Secondary C = Tertiary
52	A-C (Not Required)	REL INFO (Release Information) - Certification Indicator
53	A-C (Not Required)	ASG BEN (Assignment of Benefits) - Certification Indicator
54	**A, B, C, P Required (if applicable)**	**PRIOR PAYMENTS (Payers and Patients)** **Note:** A = Primary B = Secondary C = Tertiary **P = Due from Patient** **Enter the patient pay amount on "P" line as shown on the DMAS-122 Form furnished by the local DSS office. (See the "Exhibits" section at the end of this chapter for a sample of this form.)**
55	Not Required A, B, C, P A, B, C, P	Estimated Amount Due

Form Locator (FL)		Instructions
56	Unlabeled Field	
57	Unlabeled Field	
58	**A-C Required**	**INSURED'S NAME** - Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must correspond with this name when eligibility is confirmed. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card. Enter the insured's name used by the primary payer identified on Line A, Locator 50. Enter the insured's name used by the secondary payer identified on Line B, Locator 50. Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.
59	**Required**	**(if P. REL applicable)**
60	**A-C Required**	**CERT.-SSN-HIC.-ID NO.** - For lines A-C, enter the unique ID# assigned by the payer organization shown on Lines A-C, Locator 58. **NOTE:** The Medicaid Enrollee ID# is <u>12</u> digits.
61	Not Required	Group Name
62	Not Required	Insurance Group No.
63	**Required (if applicable)**	Treatment Authorization Codes – enter the prior authorization number if billing revenue code 2109 for coverage of a treatment bed.
64	Not Required	ESC (Employment Status Code)
65	Not Required	Employer Name
66	Not Required	Employer Location
67	**Required**	**PRIN. DIAG. CD.** - Enter the ICD-9-CM diagnosis code that

Form Locator (FL)		Instructions
		describes the principal diagnosis. **DO NOT USE DECIMALS.**
68-75	**Required (if applicable)**	**Other Diagnosis Code(s)** - Enter the codes for diagnoses other than principal if any. **DO NOT USE DECIMALS.**
76	Not Required	Adm. Diag. Cd. - Enter the ICD-9-CM diagnosis code provided at admission as stated by the physician.
77	Not Required	E-Code (External Cause of Injury Code)
78	Unlabeled Field	
79	**Required**	**P.C. (Procedure Coding Method Used)** - Enter the code identifying the coding method used in Locators 80 and 81 as follows: 5 - HCPCS 9 - ICD-9-CM Refer to the *State UB-92 Manual* for other codes.
80	**Required (if applicable)**	**Principal Procedure Code and Date** - Enter the ICD-9-CM procedure code for the principal procedure performed during the billing period.
81	**Required (if applicable)**	**Other Procedure Codes & Dates** - Enter the code(s) identifying all significant procedures, other than the principal procedure, as well as the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal. **DO NOT USE DECIMALS.**
82	**Required**	**ATTENDING PHYS. ID. NUMBER -** Enter the attending physician's seven-to-nine-digit Medical Assistance Program Identification Number. If the physician does not participate in the Virginia Medical Assistance Program, use the following number 99-0002-1 (Practitioner, Non-Participating).

Form Locator (FL)		Instructions
83	**Required (if applicable)**	**OTHER PHYS. ID** - Instructions are the same as for the attending physician in Locator 82 above.
84	**Required (if applicable)**	**REMARKS** - Enter a brief description of the reason for the submission of the adjustment or void (refer to Locator 37). Also, if there is a delay in filing, indicate the reason for the delay here and include an attachment. Also, provide any other information necessary to adjudicate the claim.
85	**Required**	**PROVIDER REPRESENTATIVE** - Enter the authorized signature indicating that the information entered on the face of this bill is in conformance with the certifications on the back of the bill. Required for paper claims only.
86	**Required**	**Date -** Enter the date on which the bill is submitted to Medicaid. Required for paper claims only.

ADJUSTMENT INVOICE INSTRUCTIONS

The UB-92 (CMS-1450) Claim Form is used as an adjustment invoice to change information on a paid claim. Only one line may be billed on an adjustment invoice. Follow the previous instructions for completion of the UB-92 (CMS-1450) Claim Form except for the locators indicated below:

Form Locator (FL)		Instructions
4	**Required**	**Type of Bill - Enter the type of bill:** **217 Adjustment Nursing Facility Invoice** **227 Skilled Nursing Inpatient Invoice – Adjustment** **617 Adjustment Specialized Care Invoice** **627 Intermediate Care Inpatient Invoice – Adjustment**
37	**Required**	**Claim Reference Number** - Enter the nine-to-sixteen-digit claim reference number of the paid claim. This number can be obtained from the Remittance Voucher and is required to identify the paid claim that is to be adjusted. **Note**: Only a paid claim may be adjusted.
84	**Required**	**Remarks** - Enter a brief explanation of the reason for the adjustment. **Reasons for Adjustment:** **Reason Code: Explanation:** 1021 Late Charges 1023 Primary Carrier Paid Part 1026 Patient Pay Changed 1025 Accommodation Charge Correction 1053 Other

VOID INVOICE INSTRUCTIONS

The UB-92 (CMS-1450) Claim Form is used as a void invoice when the full payment is to be returned to the Virginia Medical Assistance Program. Only one line may be billed on a void invoice. Follow the previous instructions for completion of the UB-92 (CMS-1450) Claim Form except for the locators indicated below:

Form Locator (FL)		Instructions
4	**Required**	**Type of Bill - Enter the type of bill:** **218 Adjustment Nursing Facility Invoice** **228 Skilled Nursing Inpatient Invoice, Void** **618 Adjustment Specialized Care Invoice** **628 Intermediate Care Inpatient Invoice, Void**
37	**Required**	**Claim Reference Number** - Enter the nine-to-sixteen-digit claim reference number of the paid claim. This number can be obtained from the Remittance Voucher and is required to identify the paid claim that is to be adjusted.
84	**Required**	**Remarks -** Enter a brief explanation of the reason for the void.

Reason Code	**Explanation:**
1045	Used Incorrect Recipient Number
1052	Other
1048	Primary Carrier Paid Full Charge

INSTRUCTIONS FOR BILLING MEDICARE CO-INSURANCE AND DEDUCTIBLE

Virginia Medicaid purchases Medicare Part A and Part B coverage for all Medicaid recipients eligible for Medicare benefits and makes payment to providers for Medicare co-insurance and deductible.

The Medicare Program Part A and Part B carriers serving Virginia and the Virginia Medicaid Program have developed a system whereby these carriers will send to Virginia Medicaid the Medicare Explanation of Benefits (EOB) for identified Virginia recipients. This information will be used by the program to pay Medicare co-insurance and deductible amounts as determined by the carrier. Do not bill Virginia Medicaid directly for services rendered to Medicaid recipients, who are also covered by Medicare Program Part A and Part B carriers serving Virginia. However, the DMAS-31 Adjustment Form may be used when needed.

If the Medicare Part A and Part B carrier is one of those serving Virginia and the Virginia Medicaid Program, bill Medicare directly on the appropriate invoice.

Upon receipt of the Medicare EOB, Virginia Medicaid will process payment automatically to participating providers when the recipient's Medicare number and the provider's Medicare vendor/provider number are in the Medicaid files. Those providers billing Medicare under more than one Medicare vendor/provider number must identify these numbers and names to the Medicaid Program to update its files. Medicare vendor/provider number additions or deletions must also be sent to the program.

This automatic payment procedure includes Medicaid recipients with Railroad Retirement Medicare benefits.

If problems are encountered, the DMAS-30 R 6/03 Claim Form should be completed, and a copy of the EOB attached and forwarded to:

Department of Medical Assistance Services
Title XVIII
P. O. Box 27441
Richmond, Virginia 23261-7441

NOTE: Medicaid eligibility is reaffirmed each month for most recipients. Therefore, bills must be for services provided during each calendar month (e.g., 01-01-99 - 01-31-99).

See the "Exhibits" section at the end of this chapter for a sample of this form.

INSTRUCTIONS FOR BILLING MEDICARE CO-INSURANCE AND DEDUCTIBLE FOR PART A AND OUTPATIENT HOSPITAL SERVICES

If payment is not received from Medicaid within 60 days of the Medicare payment, the provider should complete and submit the UB-92 CMS Claim Form.

The following description outlines the process for completing the UB-92 CMS-1450 for Medicare Part A and Outpatient Hospital Services. It includes Medicaid-specific information and should be used to supplement the material included in the *State UB-92 Manual.*

Locator		Instructions
1	**Required**	Enter the provider's name, address, and telephone number.
2	Unlabeled Field	
3	**Required (if applicable)**	**PATIENT CONTROL NUMBER** - Medicaid will accept an account number, which does not exceed 17 alphanumeric characters.
4	**Required**	**TYPE OF BILL** - Enter the code as appropriate. Refer to the UB-92 billing instructions in your Medicaid Provider Manual. * The proper use of these codes (see the *State UB-92 Manual*) will enable DMAS to reassemble cycle-billed claims to form DRG cases for purposes of DRG payment calculations.
5	Not Required	**FED. TAX No.**
6	**Required**	**STATEMENT COVERS PERIOD** - Enter the beginning and ending service dates (in MM/DD/YY-MM/DD/YY format) reflected by this invoice (include both covered and non-covered days). Use both "from" and "to" for a single day. Refer to the UB-92 billing instructions in your Medicaid Provider Manual.
7	**Required**	**COV D. (Covered Days)** - Enter the total number of Medicaid-covered days as applicable. This should be the total number of covered accommodation days/units reported in Locator 46.

Locator		Instructions
8	**Required**	**N-CD. (Non-Covered Days)** - Enter the days of care not covered for inpatient only. Non-covered days are not included in covered days. (Not required for outpatient rehabilitation agencies.)
9	Not Required	C-ID. (Co-insurance Days)
10	Not Required	L-RD. (Lifetime Reserve Days)
11	**Required**	**Enter the word "CROSSOVER"**
12	**Required**	**PATIENT NAME** - Enter the patient's name (last, first, and middle initial).
13	**Required**	**PATIENT ADDRESS** - Enter the patient's address.
14	**Required**	**BIRTH DATE** - Enter the month, date, and full year (MMDDYYYY).
15	**Required**	**SEX** - Enter the sex of the patient as recorded on the date of admission, outpatient service, or start of care.
16	**Optional**	**MS (Patient's Marital Status)**
17	**Required**	**DATE (Admission Date)** - Enter the date of admission for inpatient care. This date must be the same date for all interim claims related to the same admission. Enter the date of service for outpatient care.
18	**Required**	**HR (Admission Hour)** - Enter the hour during which the patient was admitted for inpatient or outpatient care.
19	**Required**	**TYPE (Type of Admission)** - For inpatient services only, enter the appropriate code indicating the priority of admission. A code "1" (emergency) indicates that a co-pay does not apply.
20	**Required**	**SRC (Source of Admission)** - Enter the appropriate code for the source of the admission. Code "7" (Emergency Room) indicates co-pay does not apply.
21	**Required**	**D HR (Discharge Hour)** - Enter the hour the patient was discharged from inpatient care.

Locator		Instructions
22	**Required**	**STAT (Patient Status)** - Enter the status code as of the ending date in Statement Covers Period (Locator 6). Correct reporting of the patient status code will facilitate quick and accurate determination of DRG reimbursement. In particular, accurate reporting of the values 01, 02, 05, and 30 are very important in DRG methodology.
23	**Required (if applicable)**	**MEDICAL RECORD NO.** - Enter the number assigned to the patient's medical/health record by the provider for history audits. NOTE: This number should not be substituted for the Patient Control Number (Loc. 3 which is assigned by the provider to facilitate retrieval of the individual financial record).
24-30	**Required (if applicable)**	**CONDITION CODES** - Enter the code(s) in numerical sequence (starting with 01), which identify conditions relating to this bill that may affect payer processing. Include the Special Program Indicator codes listed below, if applicable: A1 EPSDT A4 FAMILY PLANNING A7 INDUCED ABORTION/DANGER TO LIFE A8 INDUCED ABORTION/VICTIM RAPE/INCEST
31	Unlabeled Field	
32-35	**a-b Required (if applicable)**	**OCCURRENCE CODES AND DATES** - Enter the code(s) in numerical sequence (starting with 01) and the associated dates to define a significant event relating to this bill that may affect payer processing. This is important when billing for days that were exhausted by Medicare.
36	**a-b Required (if applicable)**	**OCCURRENCE SPAN CODES AND DATES** - Enter the code(s) and related dates that identify an event related to the payment of this claim. If code 71 is used, enter the FROM/THROUGH dates given by the patient for any hospital, skilled nursing facility (SNF), or nursing facility stay that ended within 60 days of this hospital admission.

Locator		Instructions
37	**a-c Required (if applicable)**	**INTERNAL CONTROL NUMBER (ICN)/ DOCUMENT CONTROL NUMBER (DCN)** - Enter the claim ICN/reference number of the paid claim to be adjusted or voided. A brief explanation of the reason for the adjustment or void is required in Locator 84 (Remarks). Be sure to use the appropriate type of bill (Locator 4) in combination with the reference number from the incorrect claim. NOTE: A = Primary Payer B = Secondary Payer C = Tertiary Payer Cross-Reference to Payer Identification in Locator 50 A, B, C (Payer Identification).
38	**Optional**	**RESPONSIBLE PARTY NAME AND ADDRESS**
39-41	**Required**	**VALUE CODES AND AMOUNTS** - Enter the appropriate codes to relate amounts or values to identified data elements necessary to process this claim. Line a **83 = Billed and Paid (enter amount paid by Medicare or other insurance).** Line b **A1** = Deductible Payer A (**Enter Medicare Deductible Amount on the EOMB).** Line c **A2** = Co-Insurance Payer A (**Enter Medicare Co-Insurance amount on the EOMB).** **Note: Complete all information in Locators 39a through 41a first (payments by Medicare or other insurance) before entering information in Locators 39b through 41b, etc.**
42	**Required**	**REV. CD. (Revenue Codes)** - Enter the appropriate revenue code(s) for the service provided as follows: **CODE: Four digits - leading zero, left justified, if applicable.** See the Revenue Codes List under "Exhibits" in your Provider Manual for approved DMAS codes.

Locator		Instructions
43	**Required**	**DESCRIPTION** - Enter the National Uniform Billing Committee (NUBC) description and abbreviation (refer to the *State UB-92 Billing Manual*).
44	**Required (if applicable)**	**HCPCS/RATES** Inpatient: Enter the accommodation rate. Outpatient: Enter the applicable HCPCS code. For Ambulatory Surgical Centers, enter the CPT or HCPCS code on the same line that the revenue code 0490 is entered.
45	**Required (if applicable)**	**SERV. DATE** - Enter the date the service was provided.
46	**Required**	**SERV. UNITS** Inpatient: Enter the total number of covered accommodation days or ancillary units of service where appropriate. Outpatient: Enter the unit(s) of service for physical therapy, occupational therapy, or speech-language pathology visit or session (1 visit = 1 unit).
47	**Required**	**TOTAL CHARGES (by Revenue Codes)** - Enter total charge(s) pertaining to related revenue code for the current billing period as entered in the Statement Covers Period. Total charges must include only covered charges. Note: Use code "0001" for TOTAL.
48	**Optional**	**NON-COVERED CHARGES** - Reflects non-covered charges for the primary payer pertaining to the related revenue code. Note: Use revenue code "0001" for TOTAL non-covered charges. (Enter the grand total for both total charges and non-covered charges on the same line of revenue code "0001.")
49	Unlabeled Field	
50	**A-C Required**	**PAYER** - Identifies each payer organization from which the provider may expect some payment for the bill. A Enter the primary payer identification. B Enter the secondary payer identification, if applicable. C Enter the tertiary payer, if applicable.

Locator		Instructions
		NOTE: If **Medicare** is the primary or secondary payer, enter **Medicare** on line A or B. If **Medicaid** is the secondary or tertiary payer, enter **Medicaid** on Lines B or C.
51	**A-C Required**	**PROVIDER NO.** - The **Medicare** and **Medicaid** Provider ID #. Enter the number on the appropriate line. A = Primary B = Secondary C = Tertiary
52	A-C Not Required	REL INFO (Release Information - Certification Indicator)
53	A-C Not Required	ASG BEN (Assignment of Benefits - Certification Indicator)
54	**A,B,C,P Required (if applicable)**	**PRIOR PAYMENTS (Payers and Patients)** <u>Long-Term Hospitals</u> - Enter the patient pay amount on "P" line as shown on the DMAS-122 Form furnished by the local Department of Social Services office. Note: A = Primary B = Secondary C = Tertiary P = Due from Patient **<u>DO NOT ENTER THE MEDICAID CO-PAY AMOUNT.</u>**
55	A,B,C,P Not Required	ESTIMATED AMOUNT DUE
56	Unlabeled Field	
57	Unlabeled Field	
58	**A-C Required**	**INSURED'S NAME** - Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must match the enrollee name when eligibility is verified. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card.

Locator		Instructions
		• Enter the insured's name used by the primary payer identified on Line A, Locator 50. • Enter the insured's name used by the secondary payer identified on Line B, Locator 50. • Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.
59	**A-C Required**	**P. REL** - Enter the code indicating the relationship of the insured to the patient. Refer to the *State UB-92 Manual* for codes. A = Primary B = Secondary C = Tertiary
60	**A-C Required**	**CERT. - SSN - HIC - ID NO.** - For lines A-C, enter the unique ID# assigned by the payer organization shown on Lines A-C, Locator 58. NOTE: The Medicaid enrollee ID # is 12 digits.
61	**A-C Required (if applicable)**	**GROUP NAME** - Enter the name of the group or plan through which the insurance is provided.
62	**A-C Required (if applicable)**	**INSURANCE GROUP NO.** - Enter the ID#, control #, or code assigned by the carrier/administrator to identify the group.
63	Not Required	TREATMENT AUTHORIZATION CODES
64	**A-C Required (if applicable)**	**ESC (Employment Status Code)** - Enter the code used to define the employment status of the individual identified in Locator 58.
65	**A-C Required (if applicable)**	**EMPLOYER NAME** - Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.
66	**A-C Required (if applicable)**	**EMPLOYER LOCATION** - Enter the specific location of the employer in Locator 65.
67	**Required**	**PRIN. DIAG. CD. (Principal Diagnosis Code)** - Enter the ICD-9-CM diagnosis code that describes the principal diagnosis. **DO NOT USE DECIMALS.**

Locator		Instructions
68-75	**Required (if applicable)**	**Other Diagnosis Code(s)** - Enter the ICD-9-CM diagnosis code(s) for diagnoses other than principal (if any). **DO NOT USE DECIMALS.**
76	**Required**	**ADM. DIAG. CD.** - Enter the ICD-9-CM diagnosis code provided at admission as stated by the physician. **DO NOT USE DECIMALS.**
77	**Required**	**E-CODE** (External Cause of Injury Code)
78	Unlabeled Field	
79	**Required**	**P.C. (Procedure Coding Method Used)** - Enter the code identifying the coding method used in Locators 80 and 81 as follows: 5 - HCPCS 9 - ICD-9-CM Refer to the *State UB-92 Manual* for other codes.
80	**Required (if applicable)**	**PRINCIPAL PROCEDURE CODE AND DATE** - Enter the ICD-9-CM procedure code for the major procedure performed during the billing period**. DO NOT USE DECIMALS.** For outpatient claims, a procedure code must appear in this locator when revenue codes 360-369, 420-429, 430-439, and 440-449 (if covered by Medicaid) are used in Locator 42, or the claim will be denied. For inpatient claims, a procedure code or one of the diagnosis codes of V64.1 through V64.3 must appear in this locator (or in Locator 67) when revenue codes 360-369 are used in Locator 42, or the claim will be denied. Procedure code 8905 will be used by Virginia Medicaid if the locator is left blank. Procedures that are done in the Emergency Room (ER) one day prior to the recipient being admitted for an inpatient hospitalization **from** the ER may be included on the inpatient claim.
81	**A-E Required (if applicable)**	**OTHER PROCEDURE CODES AND DATES** - Enter the ICD-9 CM code(s) identifying all significant procedures, other than the principal procedure, and the dates on which the procedures were performed. Report those that are most important for the episode of care and, specifically, any therapeutic procedures closely related to the principal. **DO NOT USE DECIMALS.**

Locator		Instructions
82	**Required**	**ATTENDING PHYS. ID.** Inpatient: Enter the number assigned by Medicare or Medicaid for the physician attending the patient. Outpatient: Enter the number assigned by Medicare or Medicaid for the physician who performs the principal procedure.
83	Not Required	OTHER PHYS. ID.
84	**Required (if applicable)**	**REMARKS** - Enter a brief description of the reason for the submission of the adjustment or void (refer to Locator 37).
85	**Required**	**PROVIDER REPRESENTATIVE** - Enter the authorized signature indicating that the information entered on the face of this bill is in conformance with the certifications on the back of the bill. (Required for paper claims only.)
86	**Required**	**DATE** - Enter the date on which the bill is submitted to Medicaid. (Required for paper claims only.)

UB-92 CMS-1450 ADJUSTMENT AND VOID INVOICES

- To **adjust** a previously paid claim, complete the UB-92 CMS-1450 to reflect the proper conditions, services, and charges:
    - Type of Bill (Locator 4) - Enter code 117 for inpatient hospital services or code 137 for outpatient services.
    - Locator 37 - Enter the nine- to sixteen-digit claim reference number of the paid claim to be adjusted. The claim reference number appears on the remittance voucher.
    - Remarks (Locator 84) - Enter an explanation for the adjustment.
- To **void** a previously paid claim, complete the following data elements on the UB-92 CMS-1450:
    - Type of Bill (Locator 4) - Enter code 118 for inpatient hospital services or 138 for outpatient hospital services.
    - ICN/DCN (Locator 37) - Enter the nine- to sixteen-digit claim reference number of the paid claim to be voided. Enter an explanation in Remarks, Locator 84.

- Payer Indicator (Locator 50) - Enter “Medicaid” here.
- Medicaid Provider Number (Locator 51) - Enter the Medicaid provider number.
- Recipient ID Number (Locator 60) - Enter the recipient’s 12-digit Virginia Medicaid number.

NOTE: To adjust or void a previously paid **MEDICARE CROSSOVER CLAIM,** be sure to enter the word **“CROSSOVER”** in **Locator 11.**

The information may be typed or legibly handwritten. Mail the completed claims and attached EOMBs to:

Department of Medical Assistance Services
Title XVIII
P.O. Box 27441
Richmond, Virginia 23261-7441

Maintain the Institution copy in the provider files for future reference.

INSTRUCTIONS FOR THE COMPLETION OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND CO-INSURANCE INVOICE FOR PART B ONLY, DMAS-30 (REVISED 6/03)

Purpose: To provide a method of billing Virginia Medicaid for Medicare deductible and co-insurance.

NOTE: This form can be used for four different procedures **per** Medicaid recipient. A different form must be used for each Medicaid enrollee.

Block 01 **Provider's Medicaid ID Number** – Enter the Virginia Medicaid provider identification number assigned by Virginia Medicaid.

Block 02 **Recipient's Last Name** – Enter the last name of the patient as it appears from the enrollee's eligibility verification.

Block 03 **Recipient's First Name** – Enter the first name of the patient as it appears from the enrollee's eligibility verification.

Block 04 **Recipient ID Number** – Enter the 12-digit number taken from the enrollee's eligibility card.

Block 05 **Patient's Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.

Block 06 **Recipient's HIB Number (Medicare)** – Enter the enrollee's Medicare number.

Block 07 **Primary Carrier Information (Other Than Medicare)** – Check the appropriate block. (Medicare is not the primary carrier in this situation.)

- **Code 2 – No Other Coverage** – If there is not other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
- **Code 3 – Billed and Paid** – When an enrollee has other coverage that makes a payment which may only satisfy in part the Medicare deductible and co-insurance, check this block and enter the payment in Block 22. If the primary carrier pays as much as the combined totals of the deductible and co-insurance, do not bill Medicaid.
- **Code 5 – Billed and No Coverage** – If the enrollee has other sources for the payment of Medicare deductible and co-insurance, which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 08 **Type of Coverage (Medicare)** – **Mark type of coverage B only**.

Block 09 **Diagnosis** – Enter the principal ICD-9-CM diagnosis code, omitting the decimal. Only one diagnosis code can be entered and processed.

Block 10 **Place of Treatment** – Enter appropriate National Place of Service code.

Block 11 **Accident/Emergency Indicator** – Check the appropriate box, which indicates the reason the treatment was rendered:

- **ACC** – Accident, possible third-party recovery
- **Emer** – Emergency, not an accident
- **Other** – If none of the above

Block 12 **Type of Service** – Enter the appropriate national code describing the type of service.

Block 13 **Procedure Code** – Enter the 5-digit CPT/HCPCS code that was billed to Medicare. Each procedure must be billed on a separate line. Use the appropriate national procedure code modifier if applicable.

Block 14 **Visits/Units/Studies** – Enter the units of service performed during the "Statement Covers Period" (block 16) as billed to Medicare.

Block 15 **Date of Admission** – Enter the date of admission if applicable.

Block 16 **Statement Covers Period** – Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (through) (e.g., 03-01-03 to 03-31-03).

Block 17 **Charges to Medicare** – Enter the total charges submitted to Medicare.

Block 18 **Allowed by Medicare** – Enter the amount of the charges allowed by Medicare.

Block 19 **Paid by Medicare** – Enter the amount paid by Medicare (taken from the Medicare EOMB).

Block 20 **Deductible** – Enter the amount of the deductible (taken from the Medicare EOMB).

Block 21 **Co-insurance** – Enter the amount of the co-insurance (taken from the Medicare EOMB).

Block 22 **Paid by Carrier Other Than Medicare** – Enter the payment received from the primary carrier (other than Medicare). If Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments.)

Block 23 **Patient Pay Amount, LTC Only** – Enter the patient pay amount, if applicable.

Block 24 **Remarks** – If an explanation regarding this claim is necessary, the "Remarks" section may be used. Submit only original claim forms and attach a copy of the EOMB to the claim if applicable.

Signature Note the certification statement on the claim form, then sign and date the claim form.

INSTRUCTIONS FOR THE COMPLETION OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND CO-INSURANCE ADJUSTMENT INVOICE FOR PART B ONLY, DMAS-31 (REVISED 6/96)

Adjustment Co-insurance Invoice, DMAS-31 (Revised 6/96)

The adjustment invoice is used to change information on a **paid** claim. This form cannot be used for the follow-up of denied or pended claims.

Void Co-insurance Invoice, DMAS-31 (Revised 6/96)

The void invoice is used to void the original payment. The information on the invoice must be identical to the original invoice.

Purpose To provide a means of making corrections or changes to claims that have been approved for payment. This form cannot be used for the follow-up of denied or pended claims. (See the "Exhibits" section at the end of this chapter for a sample of this form.)

Explanation To void the original payment, the information on the adjustment invoice must be identical to the original invoice. To correct the original payment, the adjustment invoice must appear exactly as the original should have.

Block 1 **Adjustment/Void** - Check the appropriate block.

Block 2 **Provider Identification Number** – Enter the Virginia Medicaid provider identification number assigned by Virginia Medicaid.

Block 2A **Reference Number** - Enter the reference number/ICN taken from the Remittance Voucher for the line of payment needing an adjustment. The adjustment cannot be made without this number since it identifies the original invoice.

Block 2B **Reason** - Leave blank.

Block 2C **Input Code** - Leave blank.

Block 3 **Client's Name** - Enter the last name and the first name of the patient as they appear on the enrollee's eligibility card.

Block 4 **Client's Identification Number** - Enter the 12-digit number taken from the enrollee's eligibility card.

Block 5 **Patient Account Number -** Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.

Block 6 **Client HIB Number (Medicare)** - Enter the enrollee's Medicare number.

Block 7 **Primary Carrier Information (Other Than Medicare)** - Check the appropriate block. (Medicare is not the primary carrier in this situation.)

- **Code 2** - No Other Coverage –If there is no other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.

- **Code 3** - Billed and Paid - When an enrollee has other coverage that makes payment which may only satisfy in part the Medicare deductible and co-insurance, check Block 3 and enter the payment received in Block 19. If the primary carrier pays as much as the combined totals of the deductible and co-insurance, do not bill Medicaid.

- **Code 5** - Billed and No Coverage - If the enrollee has other sources for the payment of Medicare deductible and co-insurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 8 **Type Coverage (Medicare)** - Mark type of coverage "B."

Block 9 **Diagnosis** - Enter the primary ICD-9-CM diagnosis code, omitting the decimal. Only one code can be processed.

Block 9A **Place of Treatment** - Enter the appropriate National Place of Service code:

Block 10 **Accident Indicator** - Check the appropriate box which indicates the reason the treatment was rendered:

- **ACC –** Accident, possible third-party recovery
- **Emer -** Emergency, not an accident
- **Other –** Other, if none of the above

Block 11 **Type of Service** - Enter the appropriate national code describing the type of service.

Block 11A **Procedure Code** - Enter the 5-digit CPT/HCPCS code, which was billed to Medicare. Each procedure must be billed on a separate line. Use the appropriate National Procedure Code Modifier, if applicable.

Block 11B **Visits/Units/Studies** - Enter the units of service performed during the "Statement Covers Period" as billed to Medicare (Block 13).

Block 12 **Date of Admission** - Enter the date of admission (if applicable).

Block 13 **Statement Covers Period** - Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (through), e.g., 03-01-03 to 03-31-03.

Block 14 **Charges to Medicare** - Enter the total charges submitted to Medicare.

Block 15 **Allowed by Medicare** - Enter the amount of the charges allowed by Medicare.

Block 16 **Paid by Medicare** - Enter the amount paid by Medicare (taken from the EOMB).

Block 17 **Deductible** - Enter the amount of the deductible (taken from the Medicare EOMB).

Block 18 **Coinsurance** - Enter the amount of the co-insurance (taken from the Medicare EOMB).

Block 19 **Paid by Carrier Other Than Medicare** - Enter the payment received from the primary carrier (other than Medicare). If Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments.)

Block 20 **Patient Pay Amount, LTC Only** - Leave blank.

Signature Signature of the provider or the agent and the date signed are required.

Mechanics and Disposition The information may be typed or legibly handwritten. Mail the completed claims to:

Department of Medical Assistance Services
Title XVIII
P. O. Box 27441
Richmond, Virginia 23261-7441

Retain a copy for the office files.

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

- Remittance Voucher
    - **Approved** - Payment is approved or placed in a pended status for manual adjudication (the provider must not resubmit).
    - **Denied** - Payment cannot be approved because of the reason stated on the Remittance Voucher.
    - **Pended** - Claims are suspended for manual review.
- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

PENDING CLAIMS

All claims which pend will have the reasons stated. A pending claim will be approved or denied on a subsequent remittance. No action by the provider is necessary.

DENIAL MESSAGES

A denied claim is unacceptable for payment for the stated reason. Proper interpretation of the denial message will allow proper resubmission of an acceptable claim.

- **Information Incomplete (Medicare Co-insurance Billing)** - This occurs when the Virginia Medicaid Program is billed for an amount in excess of $500.00 on the deductible/co-insurance invoice without itemizing the amount being billed to the Virginia Medicaid Program.

  Action to Take: Resubmit the deductible and co-insurance claim, explaining the co-insurance as follows:

  EXAMPLE:
  Part A Co-insurance 30 days x $22.50 = $675.00

- **Please Bill Primary Carrier** - Medicaid is a last-pay program. Any claim submitted with the "Primary Carrier Information" Code 5 must have sufficient explanation or evidence of denial in the "Remarks" column of the invoice. Without such evidence, the claim is denied.

Action to Take: Bill the primary carrier. If a primary carrier denial has been received, resubmit a new invoice and explain fully in the "Remarks" column the reason for denial. Information to be included is the name of the insurance, the date of denial, the reason for the denial or non-coverage, and a statement to the effect that the denial is part of the patient's record and available for audit by the Medicaid representative.

- **Date of Service Over One-Year-Old** - Any claim for services rendered more than 12 months in the past will not be considered for payment unless the reason for the delay is prolonged eligibility determination. An explanation must be stated on the invoice. Claims for services rendered more than 24 months in the past will not be considered for payment unless a timely claim was submitted to Medicare or it is documented that negligence by the Virginia Medical Assistance Program delayed payment. This time limitation does not apply to retroactive adjustment payments. However, payments over 30 months old cannot be adjusted through the system.

  (See "Timely Filing" section earlier in this chapter.)

- **Enrollee Not Eligible on Date of Service** - This means that the enrollee was not Medicaid-eligible on the dates of service cited on the billing.

  Action to Take: Recheck the enrollee's eligibility period. If it cannot be resolved, contact the enrollee's DSS office to verify the enrollee's eligibility dates and submit a new invoice reflecting charges incurred for any treatment rendered while the enrollee was Medicaid-eligible.

- **Enrollee Canceled** - Check the enrollee's eligibility period. If as much as one day of service is billed after the enrollee's last day of coverage, the claim will be denied. In cases of death, the recipient record may not show the same date of death that the nursing facility's record indicates.

  Action to Take: Contact the local DSS office having case responsibility. If the date of death in the enrollee record is in error, DSS will make the correction. If a claim has not been paid, pended, or denied within 60 days, re-bill the program noting on the invoice that it is a second billing and the date that the original invoice was sent.

  If further assistance is needed with the above situation, contact the area "HELPLINE." (See Chapter I for telephone numbers.)

- **Duplicate/Conflicting Claim** - This is an indication that the Virginia Medicaid Program has already paid the claim as indicated by a conflicting claim (original bill), which has the remittance schedule date on which the claim was paid written beside it.

  Action to Take: Check past remittances to locate the payment for this service period. When located, review the service date for any possible conflicts and resubmit a new claim accordingly.

- **Claim Must Be For The Same Calendar Month** - Check the dates of service to ensure that the claim does not overlap calendar months.

  Action to Take: To submit a claim where the dates of services overlap two calendar months, submit two invoices, one for each specific calendar month.

SPLIT BILLING

There should be no overlap of a fiscal year-end on billing forms, regardless of the date of admission or discharge of a patient. A separate billing should be made as of the last day of the fiscal year for a clear segregation of the fiscal year in which the service was rendered.

PATIENT PAY ADJUSTMENTS

A change occurring in the patient pay amount after submission of the original invoice must be corrected with the submission of the appropriate adjustment invoice(s) for each month affected by the change. For example, charges for nursing facility care for March were billed on April 3 using a patient pay amount of $894. On April 10, the nursing facility receives a corrected Patient Pay Information Form (DMAS-122) for March showing the patient pay amount changed to $902. The nursing facility cannot increase the April patient pay amount by $8 to account for the $8 shortfall for March. The patient pay amount cannot be added or reduced on one billing adjustment invoice for more than one calendar month's billing.

EXHIBITS

APPROVED OMB NO. 0938-0279

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11

12 PATIENT NAME	13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37 A B C

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56

57 **DUE FROM PATIENT ▶**

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID

OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
	X	

UB-92 HCFA-1450 **OCR / Original**

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

PATIENT INFORMATION

Medicaid ID:_____ **Provider Name:**_____
Recipient Name:_____ **SSN:**_____ **DOB:**_____
Address:_____

I. Provider Section

Payment Status (Complete Appropriate Blocks)
Report any admission, discharge, and/or change in patient status
Patient admitted to this facility/service on :_____(date)
Level of care: ☐ Skilled ☐ Intermediate
Patient discharged or expired on _____(date)
Discharged to: ☐ Home ☐ Hospital ☐ Other Facility ☐ Expired
☐ Case in Need of Review/DMAS-122 requested
☐ Personal Funds Account balance $_____
☐ Patient's income or deductions have changed
☐ Other/explain:_____

Prepared by
Name:_____ Title:_____
Telephone:_____ Date:_____

II. DSS Section

Eligibility Information: (Check One)
☐ Is eligible for full Medicaid services beginning _____(date)
☐ Is ineligible for Medicaid services
☐ Is eligible for QMB Medicaid only
☐ Is ineligible for Medicaid payment of LTC services from _____ to _____ due to transfer of assets
☐ Is eligible for Medicare premium payment only
☐ Has Medicare Part A Insurance
☐ Has other health insurance

III. Patient Pay Information

	MMYY	MMYY	MMYY
	_____	_____	_____
Patient Pay Amount	_____	_____	_____

Comments:_____

Note: Medicaid Long-term care providers cannot collect more than the Medicaid rate from the patient. Income is used for the cost of care in the month in which it is received, e.g. the SSA check received in January is used toward the cost of care in January.

Worker Name:_____

Agency Name:_____ FIPS Code:_____

Telephone:_____ Date:_____

DMAS-122 (Rev. 12-10-98)

PATIENT INFORMATION
FORM NUMBER DMAS-122

PURPOSE OF FORM—To allow the local DSS and the nursing facility or Medicaid Community-based Care provider to exchange information regarding:

1. The Medicaid eligibility status of a patient;
2. The amount of income an eligible patient must pay to the provider toward the cost of care;
3. A change in the patient's level of care;
4. Admission or discharge of a patient to an institution or Medicaid CBC services, or death of a patient;
5. Other information known to the provider that might cause a change in the eligibility status or patient pay amounts.

USE OF FORM--Initiated by either the local DSS or the provider of care. The local DSS must complete the form for each nursing facility or CBC waiver patient at the time initial eligibility is determined or when a Medicaid enrolled recipient enters a nursing facility or CBC waiver services. A new form must be prepared by the local DSS whenever there is any change in the patient's circumstances that results in a change in the amount of patient pay of the patient's eligibility status. The local DSS must send an updated form to the provider at least once a year, even if there is no change in patient pay.

The provider must use the form to show admission date, to request a Medicaid eligibility status, Medicaid recipient I.D., and patient pay amount; to notify the local DSS of changes in the patient's circumstances, discharge or death.

NUMBER OF COPIES—Original and one copy for nursing facility patients and original and two copies for CBC patients.

DISTRIBUTION OF COPIES—For nursing facility patients, send the original to the nursing facility and file the copy in the eligibility case folder. For Medicaid CBC patients, refer to section M1470.800 B.2. to determine where the original and any copies of forms are sent.

INSTRUCTIONS FOR PREPARATION OF THE FORM—Complete the heading with the name of the nursing facility or Medicaid CBC provider, the address, the patient's name, social security number, and Medicaid recipient I.D.

Section I is for the provider to complete. Section II must be completed by the local DSS. Fill in the appropriate spaces.

Eligibility information

1. Check the first block on an initial form sent in conjunction with the approval of a new Medicaid application, showing the effective date of coverage.
2. Check the second block if the individual is ineligible for payment of **all** Medicaid services.
3. Check the third block if the individual is eligible as QMB only-(not dually eligible).
4. Check the fourth block if ineligible for Medicaid payment due to transfer of assets. Dates of disqualification must be listed on the form. Send copy to DMAS.
5. Check the fifth block if eligible for Medicare premium payment only.
6. Check the sixth block if the individual has Medicare Part A insurance.
7. Check the last block if the individual has other health insurance.

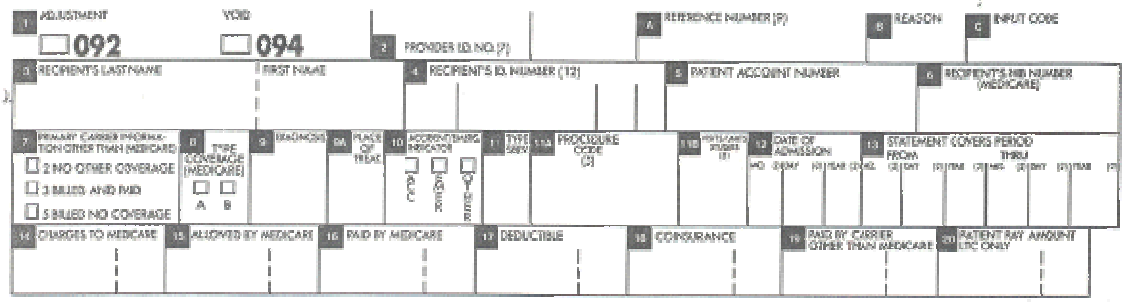
Patient Pay Information

Enter the month and year in which patient pay amount is effective. Enter the patient pay amount under the appropriate month and year.

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES



_____ DATE OF REMITTANCE VOUCHER CLAIM WAS APPROVED

THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER OF THE PAID CLAIM AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

REMARKS:

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE DATE

ORIGINAL COPY

DMAS 31 R 6/96

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

Patient Account Number (20 positions limit) **M M D D C C Y Y Sequence Number (5 digits)**

Date of Service

***Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.**

Provider Number:	**Provider Name:**

Enrollee Identification Number:

Enrollee Last Name:	**First:**	**MI:**

☐ **Paper Attached** ☐ **Photo(s) Attached** ☐ **X-Ray(s) Attached**

☐ **Other (specify)**_____

*COMMENTS:*_____

_____

_____

_____

_____

_____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

Authorized Signature _____ **Date Signed** _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.virginia.gov. Attachments are sent to the same mailing address used for claim submission. Use appropriate P.O. Box number.

INSTRUCTIONS FOR THE COMPLETION OF THE DMAS-3 FORM. THE DMAS-3 FORM IS TO BE USED BY EDI BILLERS ONLY TO SUBMIT A NON-ELECTRONIC ATTACHMENT TO AN ELECTRONIC CLAIM.

Attachment Control Number (ACN) should be indicated on the electronic claim submitted. The ACN is the combined fields 1, 2 and 3 below. (i.e. Patient Account number is 123456789. Date of service is 07/01/2003. Sequence number is 12345. The ACN entered on the claim should be 123456789070120031 2345.)
IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS OR THE CLAIM MAY RESULT IN A DENIAL.

1. **Patient Account Number** – Enter the patient account number up to 20 digits. Numbers and letters only should be entered in this field. **Do not** enter spaces, dashes or slashes or any special characters.

2. **Date of Service** – Enter the from date of service the attachment applies to.

3. **Sequence Number** –Enter the provider generated sequence number up to 5 digits only.

4. **Provider Number** – Enter the Medicaid Provider number.

5. **Provider Name** – Enter the name of the Provider.

6. **Enrollee Identification Number** – Enter the Medicaid ID number of the Enrollee.

7. **Enrollee Last Name** - Enter the last name of the Enrollee.

8. **First** – Enter the first name of the Enrollee.

9. **MI –** Enter the middle initial of the Enrollee.

10. **Type of Attachment –** Check the type of attachment or specify.

11. **Comment –** Enter comments if necessary.

12. **Authorized Signature –** Signature of the Provider or authorized Agent.

13. **Date Signed** – Enter the date the form was signed.

Attachments are sent to the same mailing address used for claim submission. Use appropriate P.O. Box number. Mailing addresses are available in the Provider Manuals or check the DMAS website at www.dmas.virginia.gov.

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

01 Provider's Medicaid ID Number	02 Last Name	03 First Name
04 Recipient ID Number	05 Patient's Account Number	06 Recipient's HIB Number (Medicare)

1

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	08 Type Of Coverage Medicare ☐ A ☐ B	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind ☐ ACC ☐ Emer ☐ Other	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies

15 Date of Admission MM DD YY	From MM DD YY	16 Statement Covers Period MM DD YY Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

2

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	08 Type Of Coverage Medicare ☐ A ☐ B	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind ☐ ACC ☐ Emer ☐ Other	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies

15 Date of Admission MM DD YY	From MM DD YY	16 Statement Covers Period MM DD YY Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

3

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	08 Type Of Coverage Medicare ☐ A ☐ B	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind ☐ ACC ☐ Emer ☐ Other	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies

15 Date of Admission MM DD YY	From MM DD YY	16 Statement Covers Period MM DD YY Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

4

07 Primary Carrier Information Other Than Medicare ☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	08 Type Of Coverage Medicare ☐ A ☐ B	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind ☐ ACC ☐ Emer ☐ Other	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies

15 Date of Admission MM DD YY	From MM DD YY	16 Statement Covers Period MM DD YY Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

24 Remarks

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE DATE

DMAS - 30 R 6/03

Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Invoice, DMAS-30 – R 6/03

Purpose: **To provide a method of billing Virginia Medicaid for Medicare deductible and coinsurance.**

NOTE: This form can be used for four different procedures **per** Medicaid recipient. A different form must be used for **each** Medicaid enrollee.

Block 01 **Provider's Medicaid ID Number** – Enter the 9-digit Virginia Medicaid provider identification number assigned by Virginia Medicaid.

Block 02 **Recipient's Last Name** – Enter the last name of the patient as it appears from the enrollee's eligibility verification.

Block 03 **Recipient's First Name** – Enter the first name of the patient as it appears from the enrollee's eligibility verification.

Block 04 **Recipient ID Number** – Enter the 12-digit number taken from the enrollee's eligibility card.

Block 05 **Patient's Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.

Block 06 **Recipient's HIB Number (Medicare)** – Enter the enrollee's Medicare number.

Block 07 **Primary Carrier Information (Other Than Medicare)** – Check the appropriate block. (Medicare is not the primary carrier in this situation.)

- **Code 2 – No Other Coverage** – If there is not other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
- **Code 3 – Billed and Paid** – When an enrollee has other coverage that makes a payment which may only satisfy in part the Medicare deductible and coinsurance, check this block and enter the payment in Block 22. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.
- **Code 5 – Billed and No Coverage** – If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 08 **Type of Coverage (Medicare)** – Mark the appropriate type of Medicare coverage.

Block 09 **Diagnosis** – Enter the principal ICD-9-CM diagnosis code, omitting the decimal. Only one diagnosis code can be entered and processed.

Block 10 **Place of Treatment** – Enter the appropriate national place of service code.

Block 11 **Accident/Emergency Indicator** – Check the appropriate box, which indicates the reason the treatment, was rendered:

- **ACC** – Accident, Possible third-party recovery
- **Emer** – Emergency, Not an accident
- **Other** – If none of the above

Block 12 **Type of Service** – Enter the appropriate national code describing the type of service.

Block 13 **Procedure Code** – Enter the 5-digit CPT/HCPCS code that was billed to Medicare. Each procedure must be billed on a separate line. If there was no procedure code billed to Medicare, leave this block blank. Use the appropriate national procedure code modifier if applicable.

Block 14 **Visits/Units/Studies** – Enter the units of service performed during the "Statement Covers Period" (block 16) as billed to Medicare.

Block 15 **Date of Admission** – Enter the date of admission

Block 16 **Statement Covers Period** – Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru) (e.g., 03-01-03 to 03-31-03).

Block 17 **Charges to Medicare** – Enter the total charges submitted to Medicare.

Block 18 **Allowed by Medicare** – Enter the amount of the charges allowed by Medicare.

Block 19 **Paid by Medicare** – Enter the amount paid by Medicare (taken from the Medicare EOMB).

Block 20 **Deductible** – Enter the amount of the deductible (taken from the Medicare EOMB).

Block 21 **Co-insurance** – Enter the amount of the co-insurance (taken from the Medicare EOMB).

Block 22 **Paid by Carrier Other Than Medicare** – Enter the payment received from the primary carrier (other than Medicare). If the Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments).

Block 23 **Patient Pay Amount, LTC Only** – Enter the patient pay amount, if applicable.

Block 24 **Remarks** – If an explanation regarding this claim is necessary, the "Remarks" section may be used. Submit only original claim forms and attach a copy of the EOMB to the claim.

Signature Note the certification statement on the claim form, then sign and date the claim form.

Nursing Facility Revenue Code Table

Revenue Code	Description	Cost Code	Inpatient
0001	Total Charge		Y
0100	All Inclusive Rate (R&B + Ancillary)	100	N
0101	All Inclusive R & B	100	Y
0110	R&B-Pvt-General	110	Y
0111	R&B-Pvt-Med-Surg-Gyn	110	Y
0112	R&B-Pvt-Obstetric	110	N
0113	R&B-Pvt-Pediatric	110	N
0114	R&B-Pvt- Psychiatric	110	N
0115	R&B-Pvt-Hospice		N
0116	R&B-Pvt-Detoxification		N
0117	R&B-Pvt-Oncology	110	N
0118	R&B-Pvt-Rehabilitation	110	N
0119	R&B-Pvt-Other	110	Y
0120	R&B-Semi-Pvt-2 Bed-General	120	Y
0121	R&B-2 Bed-Med-Surg-Gyn	120	Y
0122	R&B-2 Bed-Obstetric	120	N
0123	R&B-2 Bed-Pediatric	120	N
0124	R&B-2 Bed-Psychiatric	120	N
0125	R&B-2 Bed-Hospice		N
0126	R&B-2 Bed-Detoxification		N
0127	R&B-2 Bed-Oncology	120	N
0128	R & B-2 Bed-Rehabilitation	120	N
0129	R&B-2 Bed-Other	120	Y
0130	R&B-3-4 Bed-General	130	Y
0131	R&B-3-4 Bed-Med-Surg-Gyn	130	Y
0132	R&B-3-4 Bed-Obstetric	130	N
0133	R&B-3-4 Bed-Pediatric	130	N
0134	R&B-3-4 Bed-Psychiatric	130	N
0135	R&B-3-4 Bed-Hospice		N
0136	R&B-3-4 Bed-Detoxification		N
0137	R&B-3-4 Bed-Oncology	130	N
0138	R & B-3-4 Bed-Rehabilitation	130	N
0139	R&B-3-4 Bed-Other	130	Y
0140	R&B-Pvt-Deluxe-General		N
0141	R&B-Pvt Deluxe-Med-Surg-Gyn		N
0142	R&B-Pvt-Deluxe-Obstetric		N
0143	R&B-Pvt-Deluxe-Pediatric		N
0144	R&B-Pvt-Deluxe-Psychiatric		N
0145	R&B-Pvt-Deluxe-Hospice		N
0146	R&B-Pvt-Deluxe-Detoxification		N
0147	R&B-Pvt-Deluxe-Oncology		N
0148	R & B-Pvt Deluxe-Rehabilitation		N
0149	R&B-Pvt-Deluxe-Other		N
0150	R&B-Ward-General	150	Y
0151	R&B-Ward-Med-Surg-Gyn	150	Y
0152	R&B-Ward-Obstetric	150	N

Revenue Code	Description	Cost Code	Inpatient

0153	R&B-Ward-Pediatric	150	N
0154	R&B-Ward-Psychiatric	150	N
0155	R&B-Ward-Hospice		N
0156	R&B-Ward-Detoxification		N
0157	R&B-Ward-Oncology	150	N
0158	R & B-Ward-Rehabilitation	150	N
0159	R&B-Ward-Other	150	Y
0160	Other R&B-General	160	Y
0164	Other R&B-Sterile Environment	160	Y
0167	Other R&B-Self Care	160	N
0169	Other R&B-Other	160	Y
0170	Nursery-General	170	N
0171	Nursery-(Level I) Normal Newborn	171	N
0172	Nursery-(Level II) Premature Newborn	172	N
0173	Nursery-Level III-Sick Neonate	173	N
0174	Nursery Level IV-Intensive Neonate	174	N
0179	Nursery-Other	179	N
0180	Leave Of Absence (LOA) Gen	180	Y
0181	LOA-Reserved		N
0182	LOA-Patient Convenience	182	Y
0183	LOA-Therapeutic	183	Y
0184	LOA-ICF-MR, Any Reason	184	Y
0185	LOA-Nursing Home for Hospital	185	Y
0189	LOA-Other	189	Y
0190	Subacute Care-General		N
0191	Subacute Care-Level I-Skilled Care		N
0192	Subacute -Level II-Comprehensive C		N
0193	Subacute-Level-III-Complex Care		N
0194	Subacute-Level-IV-Intensive Care		N
0199	Subacute Care-Other		N
0200	Intensive Care (ICU)-General	200	N
0201	ICU-Surgical	200	N
0202	ICU-Medical	200	N
0203	ICU-Pediatric	200	N
0204	ICU-Psychiatric	200	N
0206	ICU-Intermediate	200	N
0207	ICU-Burn Care	207	N
0208	ICU-Trauma	200	N
0209	ICU-Other	200	N
0210	Coronary Care (CCU)-General	210	N
0211	CCU-Myocardial Infarction	210	N
0212	CCU-Pulmonary	210	N
0213	CCU-Heart Transplant	210	N
0214	CCU-Intermediate	210	N
0219	CCU-Other	210	N
0220	Special Charges-General		N
0221	Special Charges-Admit Charge		N
0222	Special Charges-Technical Support		N
0223	Special Charges-U.R. Service Charge		N
0224	Special Charges-Late D/C, Med Nec	224	N
0229	Special Charges-Other		N

Revenue Code	**Description**	**Cost Code**	**Inpatient**
0230	Incremental Nsg. Care Rate-Gen	230	Y

0231	Increm Nsg. Care Rate-Nursery	230	N
0232	Increm Nsg. Care Rate-Obstetric	230	N
0233	Increm Nsg. Care Rate-ICU	230	N
0234	Increm Nsg. Care Rate-CCU	230	N
0235	Increm Nsg. Care Rate-Hospice		N
0239	Increm Nsg. Care Rate-Other	230	Y
0240	All Inclusive Ancillary-General	240	N
0241	All Inclusive Ancillary-Basic	240	N
0242	All Inclusive Ancillary-Comprehensive	240	N
0243	All Inclusive Ancillary-Specialty	240	N
0249	All Inclusive Ancillary-Other	240	N
0250	Pharmacy (Drugs)-General	250	N
0251	Drugs-Generic	250	N
0252	Drugs-Non-Generic	250	N
0253	Drugs-Take Home	250	N
0254	Drugs-Incident to Other Diagnostic S	250	N
0255	Drugs-Incidental to Radiology	250	N
0256	Drugs-Experimental		N
0257	Drugs-Non-Prescription	250	N
0258	Drugs-I.V. Solutions	250	N
0259	Drugs-Other	250	N
0260	I.V. Therapy-General	260	Y
0261	I.V. Therapy-Infusion Pump	260	Y
0262	I.V. Therapy-Pharmacy Services	260	Y
0263	I.V. Therapy-Drug-Supply Delivery	260	Y
0264	I.V. Therapy-Supplies	260	Y
0269	I.V. Therapy-Other	260	Y
0270	Med-Surg. Supplies-General	270	Y
0271	Med-Surg. Supplies-Non-Sterile	270	Y
0272	Med-Surg. Supplies-Sterile	270	Y
0273	Med-Surg. Supplies-Take Home	270	Y
0274	Med-Surg. Suppl-Prosthetic-Orthotic	270	Y
0275	Med-Surg. Supplies-Pacemaker	270	N
0276	Med-Surg. Supplies-Intraocular Lens	270	N
0277	Med-Surg. Supplies-O2-Take Home	270	N
0278	Med-Surg. Supplies-Implants	270	N
0279	Med-Surg. Supplies-Other	270	Y
0280	Oncology-General	280	N
0289	Oncology-Other	280	N
0290	Durable Medical Equip.-General	290	N
0291	Medical Equip-Rental	290	Y
0292	Medical Equip-Purchase of New DME	290	N
0293	Medical Equip-Purchase 0f Used DME	290	N
0294	Med- Equip-Supplies/Drugs for DME		N
	Effectiveness (HH Agency Only)		N
0299	Medical Equip-Other	290	N

Revenue Code	Description	Cost Code	Inpatient
0300	Laboratory (Lab)-General	300	Y

0301	Lab-Chemistry	300	Y
0302	Lab-Immunology	300	Y
0303	Lab-Renal Patient (Home)		N
0304	Lab-Non-Routine-Dialysis	300	Y
0305	Lab-Hematology	300	Y
0306	Lab-Bacteriology-Microbiology	300	Y
0307	Lab-Urology	300	Y
0309	Lab-Other	300	Y
0310	Pathology Lab (Path Lab)-General	310	Y
0311	Path Lab-Cytology	310	Y
0312	Path Lab-Histology	310	Y
0314	Path Lab-Biopsy	310	Y
0319	Path Lab-Other	310	Y
0320	Dx X-Ray-General	320	Y
0321	Dx X-Ray-Angiocardiography	320	Y
0322	Dx X-Ray-Arthrography	320	Y
0323	Dx X-Ray-Arteriography	320	Y
0324	Dx X-Ray-Chest	320	Y
0329	Dx X-Ray-Other	320	Y
0330	Therapeutic X-Ray (Rx X-Ray)-Gen	330	Y
0331	Rx X-Ray-Chemotherapy-Injected	330	Y
0332	Rx X-Ray-Chemotherapy-Oral	330	Y
0333	Rx X-Ray-Radiation Therapy	330	N
0335	Rx X-Ray-Chemotherapy-I.V.	330	Y
0339	Rx X-Ray-Other	330	Y
0340	Nuclear Medicine (Nuc Med)-General	340	Y
0341	Nuclear Medicine-Diagnostic	340	Y
0342	Nuclear Medicine-Therapeutic	340	Y
0349	Nuclear Medicine-Other	340	Y
0350	CT Scan-General	350	Y
0351	CT Scan-Head	350	Y
0352	CT Scan-Body	350	N
0359	CT Scan-Other	350	Y
0360	Operating Room (OR) Services	360	N
0361	OR Services-Minor Surgery	360	N
0362	OR Serv-Organ Trans-other than Kidn	360	N
0367	OR Serv-Kidney Transplant	360	N
0369	OR Services-Other	360	N
0370	Anesthesia-General	370	N
0371	Anesthesia-Incident to Radiology	370	N
0372	Anesthesia-Incident to Other Diag	370	N
0374	Anesthesia-Acupuncture		N
0379	Anesthesia-Other	370	N
0380	Blood-General	380	Y
0381	Blood-Packed Red Cells	380	Y
0382	Blood-Whole	380	Y
0383	Blood-Plasma	380	Y
0384	Blood-Platelets	380	Y
0385	Blood-Leucocytes	380	Y
0386	Blood-Other Components	380	Y

Revenue Code	**Description**	**Cost Code**	**Inpatient**
0387	Blood-Other Derivatives (Cryopricipit)	380	Y
0389	Blood-Other	380	Y

0390	Blood Storage-Processing-Gen	390	Y
0391	Blood Storage-Administration	390	Y
0399	Blood Storage-Other	390	Y
0400	Imaging Services-General	400	Y
0401	Imaging Serv-Diag.-Mammography	400	Y
0402	Imaging Serv-Ultrasound	400	Y
0403	Imag Serv-Screening Mammogram	400	N
0404	Imag Serv-Positron Emission Tom	400	N
0409	Imaging Services-Other	400	Y
0410	Respiratory Services-General	410	Y
0412	Respir Serv-Inhalation	410	Y
0413	Respir Serv-Hyperbaric O2	410	Y
0419	Respir Serv-Other	410	Y
0420	Physical Therapy (P.T.)-General	420	Y
0421	P.T.-Visit Charge	420	Y
0422	P.T.-Hourly Charge	420	Y
0423	P.T.-Group Rate	420	Y
0424	P.T.-Evaluation or Re-evaluation	420	Y
0429	P.T.-Other	420	Y
0430	Occupational Therapy (O.T.)-General	430	Y
0431	O.T.-Visit Charge	430	Y
0432	O.T.-Hourly Charge	430	Y
0433	O.T.-Group Rate	430	N
0434	O.T.-Evaluation or Re-evaluation	430	Y
0439	O.T.-Other	430	Y
0440	Speech–Language Pathology-General	440	Y
0441	Speech Path-Visit Charge	440	Y
0442	Speech Path-Hourly Charge	440	Y
0443	Speech Path-Group Rate	440	Y
0444	Speech Path-Evaluation or Re-evaluation	440	Y
0449	Speech–Language Path-Other	440	Y
0450	Emergency Room-General	450	N
0451	EMTALA-Emerg Med-Screen ServIce	450	N
0452	ER Beyond EMTALA Screening	450	N
0456	Urgent Care	450	N
0459	Emergency Room-Other	450	N
0460	Pulmonary Function-General	460	Y
0469	Pulmonary Function-Other	460	Y
0470	Audiology-General	470	N
0471	Audiology-Diagnostic	470	N
0472	Audiology-Treatment	470	N
0479	Augiology-Other	470	N
0480	Cardiology-General	480	N
0481	Cardiology-Cardiac Cath Lab	480	N
0482	Cardiology-Stress Test	480	N
0483	Cardiology-Echocardiology	480	N
0489	Cardiology-Other	480	N
0490	Ambulatory Surgical Care-General	490	N
0499	Ambulatory Surgical Care-Other	490	N
0500	Outpatient Services-General	500	N

Revenue Code	**Description**	**Cost Code**	**Inpatient**
0509	Outpatient Services-Other	500	N
0510	Clinic-General	510	N

0511	Clinic-Chronic Pain Center	510	N
0512	Clinic-Dental Clinic	510	N
0513	Clinic-Psychiatric	510	N
0514	Clinic-OB-GYN	510	N
0515	Clinic-Pediatric	510	N
0516	Clinic-Urgent Care	510	N
0517	Clinic-Family Practice	510	N
0519	Clinic-Other	510	N
0520	Free-Standing Clinic-General	510	N
0521	Free-Stand Clinic-Rural Health Clinic		N
0522	Free-Stand Clinic-Rural Home Health		N
0523	Free-Stand Clinic-Family Practice		N
0526	Free-Stand Clinic-Urgent Care		N
0529	Free-Standing Clinic-Other		N
0530	Osteopathic Services-General	530	N
0531	Osteopathic Services-Therapy	530	N
0539	Osteopathic Services-Other	530	N
0540	Ambulance-General	540	N
0541	Ambulance-Supplies	540	N
0542	Ambulance-Med Transport	540	N
0543	Ambulance-Heart Mobile	540	N
0544	Ambulance-Oxygen	540	N
0545	Ambulance-Air Ambulance	540	N
0546	Ambulance-Neonate	540	N
0547	Ambulance-Pharmacy	540	N
0548	Amb-Telephone Transmission EKG	540	N
0549	Ambulance-Other	540	N
0550	Skilled Nursing-General		N
0551	Skilled Nursing-Visit Charge		N
0552	Skilled Nursing-Hourly Charge		N
0559	Skilled Nursing-Other		N
0560	Medical Social Serv-General		N
0561	Medical Social Serv-Visit Charge		N
0562	Medical Social Serv-Hourly Charge		N
0569	Medical Social Serv-Other		N
0570	Home Health Aide-General		N
0571	Home Health Aide-Visit Charge		N
0572	Home Health Aide-Hourly Charge		N
0579	Home Health Aide-Other		N
0580	Other Visit-General		N
0581	Other Visit-Visit Charge		N
0582	Other Visit-Hourly Charge		N
0589	Other Visit-Other		N
0590	Home Health-Units of Serv-General		N
0599	Home Health-Units of Service-Other		N
0600	Oxygen (O2) (HH)-General		N
0601	O2 (HH)-State-Equip-Supply-Cont		N
0602	O2 (HH)-State-Equip-Supply-<1 lpm		N
0603	O2 (HH)-State-Equip-Suppy->4 lpm		N

Revenue Code	Description	Cost Code	Inpatient
0604	Oxygen (HH)-Portable-Add-on		N
0609	Oxygen, Home Health-Other		N

0610	Magnetic Resonance Technology	610	Y
0611	MRI-Brain (Including Brainstem)	610	Y
0612	MRI-Spinal Cord (Including Spine)	610	N
0613	Reserved		N
0614	MRI-Other	610	N
0615	MRA-Head and Neck	610	N
0616	MRA-Lower Extremities	610	N
0617	Reserved		N
0618	MRA-Other	610	N
0619	MRT-Other	610	Y
0621	Med-Sur-Sup-Incident Radiology	620	Y
0622	Med-Sur-Sup-Incident-Other Diagnostic	620	Y
0623	Med-Sur-Sup-Surgical Dressings	620	N
0624	Med-Sur-Sup-FDA Invest Device		N
0630	Pharmacy Extension-Reserved		N
0631	Pharmacy-Single Source Drug	630	N
0632	Pharmacy-Multiple Source Drug	630	N
0633	Pharmacy-Restrictive Prescription	630	N
0634	Pharmacy-EPO-less than 10,000 Units	630	N
0635	Pharmacy-EPO-10,000 Units or more	630	N
0636	Pharmacy-Requiring Detailed Coding	630	N
0637	Pharmacy-Self-administrable	630	N
0640	Home (H) I.V.Therapy-General		N
0641	H-IV Therapy-Cent. Line-non-rout		N
0642	H-IV Therapy-Site Care-Cent line		N
0643	H- IV Therapy-IV Start-Chg-Peri li		N
0644	H-IV Therapy-Periph Line-non-rou		N
0645	H-IV Therapy-Train-Pat/CareGiv-CL		N
0646	H-IV Therapy-Train-Disabled Pt.-CL		N
0647	H-IV Therapy-Train-Pat/CareGiv-PL		N
0648	H-IV Therapy-Train-Disabled Pt.-PL		N
0649	H-IV Therapy-Other		N
0650	Hospice Services-General		N
0651	Hospice Serv-Routine-Home Care		N
0652	Hospice Serv-Continuous Home Care		N
0653	Hospice Services-Reserved		N
0654	Hospice Services-Reserved		N
0655	Hospice Serv-Inpatient Respite Care		N
0656	Hospice Serv-General Inpatient Care		N
0657	Hospice Serv-Physician Services		N
0659	Hospice Serv-Other Hospice		N
0660	Respite Care (HHA only)-General		N
0661	Respite Care-Hourly Chg-Skill Nsg		N
0662	Respite Care-Hourly Chg-HH Aide		N
0663	Respite Care-Daily Charge		N
0669	Respite Care-Other		N

Revenue Code	Description	Cost Code	Inpatient
0670	Outpt Special Resid Chg-General		N
0671	Outpt Special Resid-Hosp Based		N
0672	Outpt Special Resid-Contracted		N
0679	Outpt Special Resid Chg-Other		N

0680	Trauma Response Not Used		N
0681	Trauma Response - Level I		N
0682	Trauma Response - Level II		N
0683	Trauma Response - Level III		N
0684	Trauma Response - Level IV		N
0689	Trauma Response - Other		N
069X	Not Assigned		N
0700	Cast Room-General	700	N
0709	Cast Room-Other	700	N
0710	Recovery Room-General	710	N
0719	Recovery Room-Other	710	N
0720	Labor Room-Delivery-General	720	N
0721	Labor-Delivery-Labor	720	N
0722	Labor Delivery-Delivery	720	N
0723	Labor Delivery-Circumcision	720	N
0724	Labor Delivery-Birthing Center	720	N
0729	Labor Delivery-Other	720	N
0730	EKG-ECG-General	730	Y
0731	EKG-ECG-Holter Monitor	730	Y
0732	EKG-ECG-Telemetry	730	Y
0739	EKG-ECG-Other	730	Y
0740	EEG-General	740	Y
0749	EEG-Other	740	Y
0750	Gastro-Intestinal Services-General	750	N
0759	Gastro-Intestinal Services-Other	750	N
0760	Treatment-Observation Room-General	760	N
0761	Treatment Room	760	N
0762	Observation Room	760	N
0769	Treatment Room-Observation-Other	760	N
0770	Preventive Care Services-General	770	N
0771	Prevent Care Serv-Vaccine Admin	770	N
0779	Preventive Care Services-Other	770	N
0780	Telemedicine-General	780	N
0789	Telemedicine-Other	780	N
0790	Lithotrispy-General	790	N
0799	Lithotripsy-Other	790	N
0800	Inpat-Renal Dialysis-General	800	N
0801	Inpatient Dialysis-Hemodialysis	800	N
0802	Inpatient Dialy-Peritoneal-Non-CAPDs	800	N
0803	Inpatient Dialysis-CAPD	800	N
0804	Inpatient Dialysis-CCPD	800	N
0809	Inpatient Dialysis-Other	800	N
0810	Organ Acquisition-General	810	N
0811	Organ Acquisition-Living Donor	810	N
0812	Organ Acquisition-Cadaver Donor	810	N
0813	Organ Acquisition-Unknown Donor	810	N
0814	Unsuccessful Organ Search-		N
0815	Donor Bank Charge	810	N

Revenue Code	**Description**	**Cost Code**	**Inpatient**
0820	Organ Acquis-Other Donor	810	N
0821	Hemodialysis Outpt or Home-General	820	N
0822	Hemodia-Opt or Home-Composite rate	820	N
0823	Hemodia-Opt or Home-Supplies	820	N

0824	Hemodia-Opt or Home-Equipment	820	N
0825	Hemodia-Opt or Home-Maint-100%	820	N
0829	Hemodia-Opt or Home-Supp Servic	820	N
0830	Hemodia-Opt or Home-Other	820	N
0831	Peritoneal Opt or Home-General	830	N
0832	Peritoneal Opt or Home-Composite	830	N
0833	Peritoneal Opt or Home-SupplieS	830	N
0834	Peritoneal Opt or Home-Equipment	830	N
0835	Peritoneal Opt or Home-Maint-100%	830	N
0839	Peritoneal Opt or Home-Suppt Servi	830	N
0840	Peritoneal Opt or Home-Other	830	N
0841	CAPD Opt or Home-General	840	N
0842	CAPD Opt or Home-Composite Rate	840	N
0843	CAPD Opt or Home-Supplies	840	N
0844	CAPD Opt or Home-Equipment	840	N
0845	CAPD Opt or Home-Maint-100%	840	N
0849	CAPD Opt or Home-Support Service	840	N
0850	CAPD Opt or Home-Other	840	N
0851	CCPD Opt or Home-General	850	N
0852	CCPD Opt or Home-Composite Rate	850	N
0853	CCPD Opt or Home-Home Supplies	850	N
0854	CCPD Opt or Home-Equipment	850	N
0855	CCPD Opt or Home-Maint-100%	850	N
0859	CCPD Opt or Home-Support Services	850	N
086X	CCPD Opt or Home-Other	850	N
087X	Reserved for Dialysis-National Assign		N
0880	Reserved for Dialysis-National Assign		N
0881	Dialysis-Miscellaneous-General	880	N
0882	Dialysis-Miscell-Ultrafiltration	880	N
0889	Dialysis-Miscell-Home Dialy Aide Vis	880	N
0890	Dialysis-Miscellaneous-Other	880	N
0900	Reserved for National Assignment		N
0901	Psychiatric/Psycholog Treat-General	900	N
00902	Psych/Psycho Treat-Electroshock	900	N
0903	Psych/Psycho Treat-Milieu Ther	900	N
0904	Psych/Psycho Treat-Play Therapy	900	N
0909	Psych/Psycho Treat-Activity Ther	900	N
0910	Psych/Psycho Treatment-Other	900	N
0911	Psych/Psycho Services-General	910	N
0912	Psych/Psycho Serv-Rehabilitation	910	N
0913	Psych/Psycho Serv-Partial Hosp.	910	N
0914	Psych/Psycho Serv-Part-Hosp-Intens	910	N
0915	Psych/Psycho Serv-Individual Therapy	910	N
0916	Psych/Psycho Serv-Group Therapy	910	N
0917	Psych/Psycho Serv-Family Therapy	910	N
0918	Psych/Psycho Serv-Bio Feedback		N
0919	Psych/Psycho Serv-Testing	910	N

Revenue Code	**Description**	**Cost Code**	**Inpatient**
0920	Psych/Psycho Serv-Other	910	N
0921	Other Diagnostic Serv-General	920	Y*
0922	Other Diag. Serv-Peripheral-Vas-Lab	920	Y
0923	Other Diag. Serv-EMG	920	Y

0924	Other Diag. Serv-Pap Smear	920	Y
0925	Other Diag. Serv-Allergy Test	920	Y
0929	Other Diag. Serv-Pregnancy Test	920	Y
0932	Medical Rehab Day - Half Day		N
0940	Medical Rehab Day - Full Day		N
0941	Other Therapeutic Serv-General	940	Y**
0942	Other Therap Serv-Recreational Therap		N
0943	Other Therap Serv-Education-Training		N
0944	Other Therap Serv-Cardiac Rehab	940	N
0945	Other Therap Serv-Drug Rehab		N
0946	Other Therap Serv-Alcohol Rehab		N
0947	Other Therap Serv-Complex Medical		N
	Equipment-Routine	940	N
0949	Other Therap Serv-Complex Medical		N
0950	Equipment-Ancillary	940	N
0951	Other Therapeutic Services-Other	940	N
0952	Other Therapy Services- Reserved		N
0960	Athletic Training		N
0961	Kinesiotherapy		N
0962	Professional Fees-General		N
0963	Prof Fees-Psychiatric		N
0964	Prof Fees-Ophthalmology		N
0969	Prof Fees-Anesthesiology (MD)		N
0970	Prof Fees-Anesthetist (CRNA**)**		N
0971	Prof Fees-Other Prof. Fees		N
0972	Professional Fees-General-Delete		N
0973	Professional Fees-Laboratory		N
0974	Prof Fees-Radiology-Diagnostic		N
0975	Prof Fees-Radiology-Therapeutic		N
0976	Prof Fees-Radiology-Nuclear Med		N
0977	Prof Fees-Operating Room		N
0978	Prof Fees-Respiratory Therapy		N
0979	Prof Fees-Physical Therapy		N
0980	Prof Fees-Occupational Therapy		N
0981	Prof Fees-Speech Pathology		N
0983	Prof Fees-Emergency Room		N
0984	Prof Fees-Outpatient Services		N
0985	Prof Fees-Clinic		N
0986	Prof Fees-Medical Social Services		N
0987	Prof Fees-EKG		N
0988	Prof Fees-EEG		N
0989	Prof Fees-Hospital Visit		N
0990	Prof Fees-Consultation		N
0991	Prof Fees-Private Duty Nurse		N
0992	Patient Convenience Item-General		N
0993	Patient Conven Item-Caféteria/Guest		N
0994	Patient Conven Item-Pvt-Linen Service		N

Revenue Code	**Description**	**Cost Code**	**Inpatient**
0995	Patient Conven Item-Phone-Telegraph	N	
0996	Patient Conven Item-TV-Radio		N
0997	Patient Conven Item-Non-Pat.Rm Rent	N	
0998	Patient Conven Item-Late Discharge		N
0999	Patient Conven Item-Admission Kits	997	N

100X to	Patient Conven Item-Barber-Beauty	N
209X	Patient Conven Item-Other	N
2100	Reserved National Assignment	
2101	Reserved National Assignment	
2102	Alternative Therapy - General	N
2103	Alternative Therapy- Acupuncture	N
2104	Alternative Therapy- Accupressure	N
2105	Alternative Therapy- Massage	N
2106	Alternative Therapy- Reflexology	N
***2109	Alternative Therapy	N
211X to	Alternative Therapy- Hynosis	N
300X	Alternative Therapy- Other	N
3100	Reserved National Assignment	
3101	Reserved National Assignment	
3102	Adult Care - Not Used	N
3103	Adult Care -Medical & Social, Hourly	N
3104	Adult Care -Social, Hourly	N
3105	Adult Care -Medical & Social, Daily	N
3109	Adult Care - Social, Daily	N
311X thru	Adult Foster Care - Daily	N
999X	Adult Care - Other	N
	Reserved National Assignment	
	Reserved National Assignment	

*	Only allowed for Specialized Care provider for Enteral Feeding
**	Only allowed for Specialized Care provider for Kinetic Therapy

***** - Only allowed for prior-authorized treatment beds.**